

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

**HEALTHCHOICES BEHAVIORAL
HEALTH PROGRAM**

SOUTHEAST

Primary Contractor - County

PREFACE

On February 1, 1997, the Commonwealth introduced a new integrated and coordinated health care delivery system, known as the HealthChoices Program, to provide medical, psychiatric and substance abuse services to Medical Assistance recipients in a five county (Bucks, Chester, Delaware, Montgomery and Philadelphia) area in Southeastern Pennsylvania. On January 1, 1999, the HealthChoices Program expanded to ten counties (Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland) in Southwestern Pennsylvania. On October 1, 2001, the Commonwealth will begin phasing in the HealthChoices capitated, mandatory managed care program in ten counties (Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York) in the Lehigh/Capital area of the state. On January 31, 2001, the Commonwealth published the Public Discussion paper for the expansion of the HealthChoices Program into the remaining counties (42) of the state. The movement toward managed care recognizes the rapidly changing health care environment, responds to concerns about rising health care costs, and recognizes the need for governmental reform of publicly funded health care systems. The goals of the HealthChoices physical and behavioral health care programs are to improve the accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases.

The physical and behavioral health components of the HealthChoices Program are implemented through separate procurements. The decision to pursue a separate Contract for behavioral health management was made after an extensive public process in which input was sought and received from all segments of the stakeholder community, including private sector managed care organizations, service providers, behavioral health consumers, persons in recovery, family members, state/local government, legal advocates and other interested parties.

The Department intends to implement the HealthChoices Behavioral Health Program consistent with a vision of service systems of the future and a set of expectations about what managed behavioral health care will accomplish. Currently, three distinct avenues for the funding and/or administration of mental health and drug and alcohol services provided to Medicaid recipients exist. They are: 1) The Medicaid Fee-for-Service, voluntary enrollment managed care, and mandatory enrollment managed care programs; 2) the state mental hospital system administered by the Department's Office of Mental Health and Substance Abuse Services (OMHSAS); and 3) the community-based mental health and drug and alcohol programs funded by OMHSAS and the Department of Health (DOH), Bureau of Drug and Alcohol Programs (BDAP).

The Department is interested in contracting with entities that will: 1) facilitate efficient coordination, continuity and integration in the provision of behavioral health services; 2) coordinate the provision of behavioral health services with the physical health services component of the HealthChoices Program; and 3) coordinate behavioral health services with the broader array of publicly funded human service programs as well as the informal, community support systems of Members. Such broad-based coordination is essential to assuring appropriate access, services utilization and continuity of care for persons with serious mental illness and/or addictive diseases,

and children and adolescents with serious emotional disturbances and/or who abuse substances. In the absence of effective services, coordination and management, there is increased likelihood that children, adolescents and adults with complex psychiatric and drug and alcohol disorders will be separated from their families, either through placement in long-term treatment facilities, homelessness, or incarceration in county or state correctional facilities and will develop more serious psychiatric and substance abuse disabilities.

Because of these cross-cutting coordination needs, an essential component of the separate behavioral health procurement is to provide each county of the Commonwealth, in the HealthChoices BH mandatory managed care program with the first opportunity to enter into a capitated Agreement with the Department. The Department has taken this approach due to the unique structure of the behavioral health and human service delivery systems administered by counties under state law. Pursuant to the Commonwealth's Mental Health and Mental Retardation (MH/MR) Act of 1966 (50 P.S. § 4201 (2)), 1976 Mental Health Procedures Act (50 P.S. §§ 7105 and 7112), and the Drug and Alcohol Services Act of 1972 (71 P.S. § 1690.101 et seq.), counties administer or provide for the delivery of a broad array of publicly funded drug and alcohol and mental health services for both Medical Assistance and non-MA populations. Counties also have statutory authority for administering a broad array of publicly funded human service and correctional programs. As a result of these diverse but interrelated responsibilities, counties are in a unique position to facilitate the coordination of their existing program responsibilities with the managed behavioral health program to provide a seamless system of care for MA recipients. Moreover, based on their 35 years of experience in administering behavioral health services programs, the counties are knowledgeable about the comprehensive needs of the high risk populations included in the managed care program.

The first opportunity for a contract provision is contingent upon the county's agreement to enter into a full risk capitation contract at an actuarially sound rate as determined by the Department, and demonstrated capacity to meet the standards and requirements set forth in this document. Under the first opportunity provision, counties either individually, as joinders or in other groupings, are afforded the option to manage the behavioral health program directly, or to subcontract with a Commonwealth licensed, risk assuming private sector BH-MCO. Such subcontracts do not relieve counties of ultimate responsibility for compliance with the document's program and fiscal requirements. Counties may, however, impose additional requirements and incentives on subcontractors as may be needed to effect appropriate management oversight and flexibility in addressing local needs. Counties are also encouraged to use this opportunity to effect integrated program and fiscal management of the managed care program and the other county administered mental health and drug and alcohol services programs.

If a county chooses not to participate in this initiative, or is unable to meet the document's requirements, the Department will use a competitive process to select a Commonwealth licensed, risk assuming private sector BH-MCO. Should a private sector BH-MCO be required in one or more counties, the Department will require the affected counties to enter into written agreements with the selected private sector BH-MCOs to appropriately coordinate the delivery of behavioral health and human services.

TABLE OF CONTENTS

Preface	ii - iii
Table of Contents.....	iv-vi
HealthChoices Behavioral Health Definitions	vii-xvi
Acronyms.....	xvii-xxiv
PART I. GENERAL INFORMATION – STANDARDS & REQUIREMENTS	1
I-1. PURPOSE	1
I-2. ISSUING OFFICE	1
I-3. SCOPE	1
I-4. TYPE of AGREEMENT	2
I-5. ON-SITE REVIEWS	2
I-6. INCURRING COSTS	2
I-7. HEALTHCHOICES RATE INFORMATION.....	3
I-8. HEALTHCHOICES LIBRARY.....	3
I-9. RESPONSIBILITY TO EMPLOY WELFARE RECIPIENTS	3
I-10. INFORMATION CONCERNING SOCIALLY/ECONOMICALLY RESTRICTED BUSINESSES (SERB).....	4
I-11. CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS	4
I-12. LOBBYING CERTIFICATION and DISCLOSURE.....	5
I-13. PRIMARY CONTRACTOR RESPONSIBILITIES	5
I-14. FREEDOM OF INFORMATION AND PRIVACY ACTS	6
I-15. NEWS RELEASES	6
I-16. COMMONWEALTH PARTICIPATION	6
I-17. PROJECT MONITORING	6
 PART II. WORK STATEMENT – STANDARDS & REQUIREMENTS.....	 8
II-1. OVERVIEW	8
II-2. OBJECTIVES	8
A. General.....	8
B. Specific Objectives	8
II-3. NATURE AND SCOPE OF THE PROJECT	10
A. Enrollment Process	10
B. HealthChoices Program Eligible Groups.....	11
C. Rating Period	18
D. Termination/Cancellation	19
E. Compliance with Federal and State Laws, Regulations and Department Bulletins	20
F. False Claims.....	20
G. Major Disasters or Epidemics.....	20
H. Performance Standards and Damages.....	21

II-4. TASKS	21
A. In-Plan Services	21
B. Coordination of Care.....	24
C. Member Services	31
D. Member Disenrollment	32
E. Complaint and Grievance System.....	33
II-5. REQUIREMENTS.....	35
A. General.....	35
B. Executive Management.....	36
C. Administration	38
D. Provider Network/Relations.....	42
E. Provider Enrollment - Credentialing/Rec credentialing	44
F. Service Access	44
G. Utilization Management and Quality Management (UM/QM)	46
II-6. PROGRAM OUTCOMES and DELIVERABLES.....	49
A. Outcome Reporting.....	50
B. Deliverables	50
II-7. FINANCIAL AND REPORTING REQUIREMENTS	51
A. Financial Standards.....	51
B. Acceptance of Department Capitation Payments	57
C. Physician Incentive Arrangements	58
D. Claims Payment and Processing.....	59
E. Retroactive Eligibility Period	60
F. Financial Responsibility for Dual Eligibles.....	60
G. Risk and Contingency Funds	61
H. Return of Funds.....	62
I. In-Network Services	62
J. Third Party Liability (TPL).....	63
K. Performance Management Information System and Reporting.....	67
L. Audits.....	73
M. Claims Processing and Management Information System (MIS).....	74
N. Reference Information	74
O. Federalizing General Assistance (GA) Data Reporting.....	75
P. Disproportionate Share (DSH)/Graduate Medical Education (GME).....	75

Appendices

Contractor Integrity Provisions.....	A
Standard General Terms and Conditions	B

COMMONWEALTH OF PENNSYLVANIA

HealthChoices Behavioral Health Program

Program Standards and Requirements - Primary Contractor - County

May 1, 2001

Contractor's Responsibility to Employ Welfare Recipients	C
Lobbying Certification Form	D
Disclosure of Lobbying Activities Form	E
Provisions Concerning the Americans with Disabilities Act.....	F
Independent Enrollment Assistance Program	G
Member Complaint and Grievance System	H
Indicators of the Application of CASSP and CSP Principles	I
Treatment Philosophy for Substance Abuse and Dependency	J
BH-MCO Performance/Outcome Management System (POMS)	K
Guidelines for Consumer/Family Satisfaction Teams	L
HealthChoices Data Reporting Requirements (non-Financial)	M
Reinvestment Parameters	N
Department Data Support for MCOs	O
HealthChoices Behavioral Health Financial Reporting Requirements.....	P
Priority Populations	Q
Capitation Rate Calculation Sheets and Instructions --- Reserved	R
Psychiatric Rehabilitation Service Descriptions	S
OMHSAS and BDAP Medical Necessity Criteria.....	T
Certified Minority and Women Business Utilization	U
HealthChoices Behavioral Health Recipient Coverage document	V
Departmental Audit Requirements	W
HealthChoices Category/Program Status Coverage Chart	X
HC Behavioral Health Services Reporting & Classification Chart	Y
Procedures for MA Enrollment of Non Fee-for-Service Providers (Provider Type 80)	Z
Prior Authorization Requirements	AA
Regulations and Policies Not Applicable to the HealthChoices Program	BB

HEALTHCHOICES BEHAVIORAL HEALTH DEFINITIONS

Adjudicate - A determination to pay or reject a claim.

Affiliate - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a private sector BH-MCO, including a private sector BH-MCO subcontracting with a county, joinder, or other county grouping, or a private sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the private sector BH-MCO's or private sector BH-MCO's parent(s), directors and subsidiaries of the private sector BH-MCO, shall be presumed to be affiliates for purposes of this document. 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 interest, 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, as the case may be.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of behavioral health services under this document.

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRS) (formerly EPSDT "Wraparound") - Individualized, therapeutic mental health, substance abuse, or behavioral interventions/services developed and recommended by an interagency team and prescribed by a physician or licensed psychologist.

Behavioral Health Residential Treatment Facility – An in-plan mental health or drug and alcohol residential treatment facility.

Behavioral Health Services Provider - A provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide behavioral health services under the HealthChoices Behavioral Health Program.

Cancellation - Discontinuation of the Agreement for any reason prior to the expiration date.

Capitation - A fee the Department pays periodically to a Primary Contractor for each recipient enrolled under an Agreement for the provision of covered in-plan services, whether or not the recipient received the services during the period covered by the fee.

Care Management/Manager - see Service Management/Manager.

COMMONWEALTH OF PENNSYLVANIA

HealthChoices Behavioral Health Program

Program Standards and Requirements - Primary Contractor - County

May 1, 2001

Children and Adolescents in Substitute Care (CISC)- Children and adolescents living outside their homes in the legal custody of a public agency, in any of the following settings: shelter homes, foster family homes, group homes, supervised independent living, residential treatment facilities, residential placement (other than youth development centers) for children and adolescents who have been adjudicated dependent or delinquent.

Clean Claim – A “Clean claim” is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor’s claims processing computer system, and those originating from human errors. It does not include a claim under review for medical necessity, or a claim that is from a provider who is under investigation by a governmental agency or the Primary Contractor or MCO for fraud or abuse. However, if under investigation by the Primary Contractor or MCO, the Department must have prior notification of the investigation.

Client Information System (CIS) - The Department's automated file of eligible recipients.

Complaint – A written or verbal issue, dispute or objection presented by or on behalf of a Member regarding a participating health care provider, or the coverage, operations or management policies of a managed care plan.

Concurrent Review - A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.

County Assistance Office - The county offices of the Department which administer the Medical Assistance program at the local level. Department staff in these offices perform necessary Medical Assistance functions such as determining recipient eligibility.

County Operated BH-MCO - An entity organized and directly operated by county government to manage the purchase and provision of behavioral health services under this document.

Cultural Competency - The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Deliverables - Those documents, records, and reports furnished to the Department for review and/or approval in accordance with the terms of the Agreement.

Denial of Services - A determination made by a BH-MCO in response to a provider's request for approval to provide in-plan services of a specific duration and scope which:

- disapproves the request completely; or
- approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested service which includes a requirement for a concurrent review by the BH-MCO during the authorized period does not constitute a denial); or
- disapproves provision of the requested service(s), but approves provision of an alternative service(s).

Department - The Pennsylvania Department of Public Welfare.

Department of Public Welfare Fair Hearing - For the purposes of this document, a hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals in response to an appeal to the Department by a BH-MCO Member.

Discretionary Funds (Profit) - Capitation payments and investment income that are not expended for purchase of services for plan enrollees (in-plan, supplemental, or cost/effective alternatives), administrative costs, risk and contingency, or reinvestment.

Drug and Alcohol Addictions Professional - A nationally accredited addictions practitioner or a person possessing a minimum of a bachelor's degree in social science and two years experience in treatment/case management services for persons with substance abuse/addiction disorders.

Eligibility Verification System (EVS) - An automated system available to MA providers and other specified organizations for on-line verification of MA eligibility, MCO enrollment, third party resources, and scope of benefits.

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

Emergency Services - Covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services under the Medical Assistance Program and are needed to evaluate or stabilize an emergency medical condition.

EPSDT - The Early and Periodic Screening, Diagnosis, and Treatment Program for individuals under age 21.

Fee-for-Service (FFS) - Payment by the Department to providers on a per-service basis for health care services provided to Medical Assistance recipients.

Grievance - A request from a Member, or a provider with the Member's written permission, for a reversal of the BH-MCO's decision to deny authorization of an in-plan service prescribed for the Member by an appropriately qualified practitioner.

Health Care Quality Unit (HCQU) – Serves as the entity responsible to county mental retardation programs for the overall health status of individual screening services in county mental retardation programs.

Health Maintenance Organization (HMO) - A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed pre-paid fee.

HealthChoices (HC)- The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Medical Assistance recipients.

HealthChoices Lehigh/Capital (HC L/C) – The HealthChoices mandatory MA managed care program in Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York Counties.

HealthChoices Library - A collection of reference documents and materials, relevant to the HealthChoices physical and behavioral health programs available for use by potential and current contractors.

HealthChoices Southeast (HC-SE) Zone - The HealthChoices mandatory MA managed care program in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties.

HealthChoices Southwest (HC-SW) Zone - The HealthChoices mandatory MA managed care program in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland Counties.

Immediate Need – A situation in which, in the professional judgment of the dispensing registered pharmacist and/or prescriber, the dispensing of the drug at the time when the prescription is presented is necessary to reduce or prevent the occurrence or persistence of a serious adverse health condition.

Independent Enrollment Assistance Program (IEAP) - The program responsible to assist MA recipients in enrolling in the HC Program, including the selection of a PH-MCO and Primary

Care Practitioner, and obtaining information regarding the HC physical and behavioral health programs.

Independent Enrollment Specialist - The IEAP individual who will be responsible to assist recipients with selecting a PH-MCO and Primary Care Practitioner, and providing information about the HealthChoices physical and behavioral health programs.

In-Plan Services - Services which are included in the HC behavioral health capitation rate and are the payment responsibility of the Primary Contractor.

Interagency Team - A multi-system planning team comprised of the child, when appropriate, the adolescent, at least one accountable family member, a representative of the county mental health and/or drug and alcohol program, the case manager, the prescribing physician or licensed psychologist, in person when possible, or by consultative conference call, and as applicable, the county children and youth, juvenile probation, mental retardation, and drug and alcohol agencies, a representative of the responsible school district, BH-MCO, PH-MCO and/or PCP, other agencies that are providing services to the child or adolescent, and other community resource persons as identified by the family. The purpose of the interagency team is to collaboratively assess the needs and strengths of the child and family, formulate the measurable goals for treatment, recommend the services, treatment approaches and methods, intensity and frequency of interventions and develop the discharge goals and plan.

Joinder - Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and mental retardation program, subject to the provisions of the Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4201 (2)), or a drug and alcohol program pursuant to the Drug and Alcohol Services Act of 1972 (71 P.S. § 1690. 101 et. seq.).

Juvenile Detention Center - A publicly or privately administered, secure residential placement for:

- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;
- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and
- Children and adolescents who have been returned from some other form of disposition and are awaiting a new disposition (e.g., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Managed Care Organization (MCO) - An entity which manages the purchase and provision of physical or behavioral health services under the HC program.

Medical Necessity - Clinical determinations to establish a service or benefit which will, or is reasonably expected to:

- prevent the onset of an illness, condition, or disability;
- reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;
- assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Member - A person who is enrolled in the HC Behavioral Health Program.

Member Month - One Member covered by the HC Behavioral Health Program for one month.

Mental Health Professional - A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, and nursing who has a graduate degree and mental health clinical experience, or an RN with at least two years of mental health clinical experience.

Minority Business Enterprise - A business concern which is: a sole proprietorship, owned and controlled by a minority; a partnership or joint venture controlled by minorities in which 51% of the beneficial ownership interest is held by minorities; or a corporation or other entity controlled by minorities in which 51% of the voting interest and 51% of the beneficial ownership interest are held by minorities.

On-Site Reviews- A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor and a BH-MCO subcontractor to accept Members and to manage and administer the purchase and provision of behavioral health services under this document.

Other County Grouping - Two or more counties, at least one of which is not a joinder, which submit a single proposal to become the Primary Contractor for all of the counties in the grouping.

Out-of-Area Services - In-plan behavioral health services provided to a Member while the Member is outside the Project Area.

Out-of-Network Provider - A behavioral health services provider who does not have a written provider agreement with the BH-MCO and is therefore not included or identified as being in the

BH-MCO's provider network.

Out-of-Plan Services - Services which are not included as in-plan, capitated services, but which have been determined by the BH-MCO to be either cost effective alternatives or necessary supplements to in-plan services.

Parent - The biological or adoptive mother or father, or the legal guardian of the child, or a responsible relative or caretaker (including foster parents) with whom the child regularly resides.

Persons in Recovery - Individuals who have abstained from drugs and alcohol for at least one year following participation in drug and alcohol treatment.

Physical Health Managed Care Organization (PH-MCO) - An entity which has contracted with the Department to manage the purchase and provision of physical health services under the HC program.

Preferred Provider Organization (PPO) - A Commonwealth licensed person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred provider arrangement, as defined in 31 Pa. Code Subsection 152.2.

Prepaid Health Plan (PHP) - An entity that provides medical services to enrolled recipients, under contract with the Medicaid agency and on the basis of prepaid capitation fees, but is not subject to requirements in Section 1903(m)(2)(A) of Title XIX of the Social Security Act.

Primary Care Practitioner (PCP) - A specific physician, physician group, or a certified registered nurse practitioner operating under the scope of his/her licensure who has received an exception from the Department of Health, responsible for supervising, prescribing and providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services, and maintaining continuity of care on behalf of a Member.

Primary Contractor - A county which has a HealthChoices Agreement approved by the Department to manage the purchase and provision of behavioral health services under this document.

Primary Diagnosis - The condition established after study to be chiefly responsible for occasioning the visit for outpatient settings or admission for inpatient settings.

Prior Authorization - A determination made by an MCO to approve or deny a provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the provider's initiating provision of the requested service.

Prior Authorized Services - In-plan services for which a BH services provider must obtain, pursuant to Department approved BH-MCO policies and procedures, the BH-MCO's approval in

advance of the provider's initiating provision of the service.

Priority Population(s) - Members with serious mental illness and/or addictive disease, and children and adolescent Members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others. Drug and alcohol priority populations include child and adolescent substance abusers and persons with addictive diseases including pregnant women and women with dependent children, intravenous drug users and persons with HIV/AIDS who abuse substances. Refer to Appendix Q.

Private Sector BH-MCO - A Commonwealth licensed MCO which has contracted with the Department or subcontracted with county government to manage the purchase and provision of behavioral health services under this document.

Project Area - All counties included in the geographic boundary of a HealthChoices zone.

Provider - A person, firm, or corporation which provides behavioral health or medical services or supplies to recipients.

Provider Agreement - Any written agreement between the BH-MCO and a Provider to render clinical or professional services to recipients to fulfill the requirement of the Agreement resulting from this document.

Quality Management - A formal methodology and set of activities designed to assess the quality of services provided and which includes a formal review of care, problem identification, and corrective action to remedy any deficiencies and evaluation of actions taken.

Recipient - A person eligible to receive physical and behavioral health services under the MA Program in the Commonwealth of Pennsylvania.

Reinvestment Funds - Capitation revenues from DPW and investment income which are not expended during an Agreement year by the Primary Contractor and a BH-MCO subcontractor for purchase of services, in-plan, supplemental, or cost/effective alternatives, for Members, administrative costs and risk and contingency, but may be used in a subsequent Agreement year only as "seed money" to start-up or increase service capacity, or to provide supplemental or cost-effective alternative services, contingent upon DPW prior approval of the Primary Contractor's reinvestment spending plan.

Related Parties - Any affiliate that is related to the Primary Contractor or subcontracting BH-MCO by common ownership or control (see definition of "Affiliate") and:

- (1) Performs some of the Primary Contractor or subcontracting BH-MCO's management functions under contract or delegation; or
- (2) Furnishes services to Members under a written agreement; or
- (3) Leases real property or sells materials to the Primary Contractor or subcontracting BH-MCO at a cost of more than \$2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

Retrospective Review - A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO's payment policies and procedures.

Risk and Contingency Funds – PMPM capitation funds received by the Primary Contractor pursuant to this Agreement, which are not expended on in-plan services or administrative functions and which are in excess of the Equity Reserve required to be maintained under this Agreement. Risk and Contingency Funds do not include reinvestment funds, or funds designated in a reinvestment plan submitted to DPW.

Risk Assuming PPO - A Commonwealth licensed PPO which meets the definition of a risk assuming PPO pursuant to Pennsylvania Regulations Title 31, Chapter 152, Subsection 152.2.

Rural - Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons [U.S. Bureau of Census definition].

Service Management/Manager - The BH-MCO function/staff with responsibility to authorize and coordinate the provision of in-plan services. Care management/manager is synonymous.

Special Needs Populations - Members whose complex medical, psychiatric, behavioral or substance abuse conditions, living circumstances and/or cultural factors necessitate specialized outreach, assistance in accessing services and/or service delivery and coordination on the part of the MCO and its provider network.

Start Date - The first date on which enrollees are eligible for behavioral health services under the operational Agreement, and on which the Primary Contractor is at risk for providing behavioral health services to enrollees.

Subcontract - Any contract (except provider agreements, utilities, and salaried employees) between the Primary Contractor or a subcontracting BH-MCO and an individual, firm, university, governmental entity, or nonprofit organization to perform part or all of the BH-MCO's responsibilities.

Supplemental Services - Services which are not included as capitated in-plan services which are

available through the county mental health or drug and alcohol programs and/or provided by the BH-MCO.

Title XVIII (Medicare) - A federally financed health insurance program administered by HCFA, covering almost all Americans sixty-five (65) years old and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts: (1) Part A covers inpatient hospital services, post-hospital care in skilled nursing facilities and care in patients' homes; and (2) Part B covers primarily physician and other outpatient services.

Urban - Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more. These places must be in close geographic proximity to one another.

Urgent - Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management - The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

Waiver - A process by which a state may obtain an approval from HCFA for an exception to a federal Medicaid requirement(s).

ACRONYMS

ADA	Americans with Disabilities Act
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
AOPC	Administrative Office Pennsylvania Courts
APD	Advanced Planning Document
ARD	Accelerated Rehabilitation Decision
ASAM	American Society of Addiction Medicine
ASCII	American Standard Code for Information Interchange
BDAP	Bureau of Drug and Alcohol Programs
BDAP CIS	Bureau of Drug and Alcohol Programs' Client Information System
BEC	Basic Education Circular
BHEF	Behavioral Health Encounter File
BH-MCO	Behavioral Health Managed Care Organization
BHRS	Behavioral Health Rehabilitation Services for Children and Adolescents
BNDD	Bureau of Narcotic Drugs and Devices
BSU	Base Service Unit
C&Y	Children and Youth
CAO	County Assistance Office
CASSP	Child and Adolescent Service System Program
CAU	County Administrative Unit
CCRS	Consolidated Community Reporting System

CCYA	County Children & Youth Agency
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
C/FST	Consumer/Family Satisfaction Team
CHADD	Children with Attention Deficit Disorders
CIS	Client Information System
CISC	Children in Substitute Care
CLIA	Clinical Laboratory Improvement Amendment
COB	Coordination of Benefits
CQI	Continuous Quality Improvement
CRD/LIC	Credentials/license
CRCS	Capitation Rate Calculation Sheet
CRF	Consumer Registry File
CRNP	Certified Registered Nurse Practitioner
CRR	Community Residential Rehabilitation
CSI	Consumer Satisfaction Instruments
CSP	Community Support Program
CST	Consumer Satisfaction Team
DAP	Disability Advocacy Program
D&A	Drug and Alcohol
DEA	Drug Enforcement Agency

DHHS	U.S. Department of Health and Human Services
DME	Durable Medical Equipment
DMIRS	Data Management and Information Retrieval System
DOH	Department of Health
DPW	Department of Public Welfare
DSH	Disproportionate Share
DSM-IV	Diagnostic and Statistical Manual
DUR	Drug Utilization Review
ECC	Electronic Claims Capture
ECM	Electronic Claims Management
EIN	Employee Identification Number
EMC	Electronic Media Claims
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ER	Emergency Room
ERISA	Employee Retirement Income Security Act, 1974
EVS	Eligibility Verification System
FA	Fiscal Agent
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FRR	Financial Reporting Requirements
FST	Family Satisfaction Team
FTE	Full Time Equivalent

FTP	File Transfer Process
GA	General Assistance
GAAP	Generally Accepted Accounting Principles
GME	Graduate Medical Education
GTC	General Terms and Conditions
HC	HealthChoices
HCQU	Health Care Quality Unit
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HC-L/C	HealthChoices Lehigh/Capital
HC-N/C	HealthChoices North Central
HC-SE	HealthChoices - Southeast
HC-SW	HealthChoices - Southwest
HEDIS	Health Plan Employer Data and Information Set Standards
HIPAA	Health Insurance Portability and Accountability Act
HIO	Health Insuring Organizations
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization
IBNR	Incurred But Not Reported Claims
ICD	International Classification of Diseases
ICF	Intermediate Care Facility

ICF/MR	Intermediate Care Facilities for Persons With Mental Retardation
ID	Insurance Department
IEAP	Independent Enrollment Assistance (Program)
IFB	Invitation for Bid
IMD	Institutions For Mental Disease
ISP	Individualized Service Plan
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JDC	Juvenile Detention Center
JPO	Juvenile Probation Office
LAAM	Levo-Alpha-Acetyl-Methadol
L/C	Lehigh/Capital
LTC	Long Term Care
MA	Medical Assistance
MAID	Medical Assistance Identification Number
MAMIS	Medical Assistance Management Information System
MATP	Medical Assistance Transportation Program
MBE	Minority Business Enterprise
MBE/WBE	Minority Business Enterprise/Women Business Enterprise
MCO	Managed Care Organization
MIS	Management Information System
MR	Mental Retardation
MWBEO	Minority and Women Business Enterprise Office

MOE	Method of Evaluation
MPL	Minimum Participating Levels
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NCE	Non-Continuous Eligibility
NMP	Non-money payment
OBRA	Omnibus Budget Reconciliation Act
OCYF	Office of Children, Youth & Families
OIP	Other Insurance Paid
OIS	Office of Information Systems
OMA	Office of Medical Assistance
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
OMR	Office of Mental Retardation
ORC	Other Related Conditions
OSP	Office of Social Programs
OTC	Over The Counter
PCIS	Patient Census Information System
PCP	Primary Care Practitioner
PCPC	Pennsylvania Client Placement Criteria
PDA	Pennsylvania Department of Aging

PH-MCO	Physical Health Managed Care Organization
PHP	Prepaid Health Plan
PIN	Parents Involved Network
PMPM	Per Member Per Month
POM	Performance Outcome Measures
POMS	Performance Outcome Management System
POSNet	Pennsylvania Open Systems Network
PPO	Preferred Provider Organization
PRTF	Psychiatric Residential Treatment Facility
QARI	Quality Assurance Reform Initiative
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QSF	Quarterly Status File
RBUC	Received But Unpaid Claims
RFP	Request For Proposal
RTF	Residential Treatment Facility
SAP	Statutory Accounting Principles
SBP	State Blind Pension
SE	Southeast
SERB	Socially Economically Restricted Business
SMH	State Mental Hospital
SMM	State Medicaid Manual

SNF	Skilled Nursing Facility
SNU	Special Needs Unit
SPR	System Performance Review
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
SUR	Surveillance and Utilization Review
SURS	Surveillance and Utilization Review System
SW	Southwest
TANF	Temporary Assistance to Needy Families
TPL	Third Party Liability
TTY	Text Telephone Typewriter
UM	Utilization Management
UM/QM	Utilization Management/Quality Management
UPIN	Unique Physician Identification Number
USC	United States Congress

PART I. GENERAL INFORMATION

I-1. PURPOSE

The Pennsylvania Department of Public Welfare hereafter referred to as the Department or DPW, is the single state agency with responsibility for the implementation and administration of the Medical Assistance program (Medicaid). Medicaid is a federal and state program which provides payment of medical expenses for eligible persons who meet income or other criteria.

The purpose of this document is to set forth the standards and requirements for the HealthChoices Behavioral Health Program operating under the HealthCare Financing Administration waiver of Section 1915(b) of the Social Security Act, through counties that are Primary Contractors [to manage the purchase and provision of behavioral health services in the Commonwealth of Pennsylvania's (hereinafter referred to as the Commonwealth) mandatory managed care program called HealthChoices for eligible MA recipients statewide or in the Commonwealth of Pennsylvania].

County governments which demonstrate capacity to meet the standards and requirements for the HC's BH mandatory managed care program are provided the first opportunity to enter into a capitated contract with the Commonwealth (the "Agreement"). Subject to the Department's approval, a county may implement the Agreement directly or enter into a subcontract with a private sector BH-MCO. In areas in which the county is unable to meet the HC-BH standards and requirements or chooses not to participate in this initiative, the Department will select a Primary Contractor through a competitive process resulting in a direct contract with a qualified private sector BH-MCO.

I-2. ISSUING OFFICE

This document is issued for the Commonwealth by the Office of Mental Health and Substance Abuse Services, Department of Public Welfare.

I-3. SCOPE

This document describes behavioral health services standards and requirements with which the Primary Contractors and BH-MCO subcontractors must comply. It also includes information on the policies and procedures the Department will follow in carrying out its program management and oversight responsibilities.

A county is the smallest geographic unit for which the Department enters into a HealthChoices behavioral health contract, and the Primary Contractor must be capable of delivering specified services to all eligible recipients in the county.

I-4. TYPE of AGREEMENT

The Department enters into a full-risk prepaid capitated contract using a flat fee per eligible MA recipient in the counties. The Primary Contractor, including programs in which the county is the Primary Contractor, is responsible for all medically necessary in-plan expenses. Should the Primary Contractor incur costs which exceed the capitation payments, the Department is not responsible for providing additional funds to cover the deficits. The method of payment is monthly. Negotiations may be undertaken with Qualified Vendors demonstrating qualifications, responsibility, and capability for performing the contract work as to price and other factors.

The initial Agreement is for 36 months. Primary Contractors assume risk for providing services to enrolled individuals effective upon implementation date. Subject to the availability of state and federal funds, the Department reserves the right to renew the Agreement for one additional two year period. The Department will notify the Primary Contractor of its intention to renew prior to the expiration of the Agreement.

Requirements of this document will become part of the Agreement and are not subject to negotiation by the County. The Department will develop a transition plan should it choose to cancel or not extend a contract with one or more Primary Contractors operating the behavioral health program.

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or waiver approvals, or change in applicable federal or Commonwealth law, regulations, public policy, or at the convenience of the Department.

A Primary Contractor must be able to provide services to all eligible recipients residing within the county or counties that it proposes to serve.

I-5. ON-SITE REVIEWS

The Department conducts on-site reviews of selected Primary Contractors and subcontractors periodically. The purpose of an on-site review is to document the status of each selected Primary Contractor with respect to meeting work statement tasks and requirements described in a procurement process. The Department reserves the right to suspend implementation of the Agreement and/or Member enrollment for any Primary Contractor that does not demonstrate to the Department's satisfaction, compliance with any critical program standard.

I-6. INCURRING COSTS

The Department is not liable for any costs incurred by potential Primary Contractors in a procurement process prior to the implementation date.

I-7. HEALTHCHOICES RATE INFORMATION

The Department releases historical cost data by Category of Aid and Category of Service for the entire zone. Additional data and/or information may also be provided to assist the Primary Contractor in constructing its capitation rate proposal.

I-8. HEALTHCHOICES LIBRARY

Documents relevant to the HealthChoices program are available for review in the HealthChoices Library at the Harrisburg State Hospital. The documents available from the Department include but are not limited to:

- A. HC rate information, a profile of HC behavioral health eligible population, demographics and health service utilization for the counties.
- B. State Medicaid Plan
- C. Medical Assistance Eligibility Handbook
- D. Fee-for-Service fee schedule
- E. HealthChoices Behavioral Health Financial Reporting Requirements
- F. Independent Enrollment Assistance RFP
- G. Child Protective Services Law, the Juvenile Act, and applicable regulations
- H. Medicaid Health Plan Employer Data and Information Set (HEDIS) Standards
- I. Telecommunications Standards and Data Interface Standards
- J. Mental health and drug and alcohol statutes, regulations, and guidelines
- K. Smoking in Children's Facilities Prohibition
- L. Managed Care Data Support Overview for Behavioral Health
- M. HealthChoices '96 Performance Outcome Measurement System (Draft)
- N. Performance Management Outcome System Reporting Manual
- O. Aggregate Encounter and Complaint and Grievance Reporting Manuals
- P. HealthChoices Requirements and Specifications Manual for Encounter Data/Subcapitation Financial Data
- Q. Transition Monitoring
- R. Quarterly Monitoring Reports
- S. HC Readiness Review Document
- T. Program materials for Psychiatric Rehabilitation Services for Adults
- U. DPW Protocol for Impartial Review
- V. HealthChoices Behavioral Health Policy Clarifications HC-SE, HC-SW

I-9. RESPONSIBILITY TO EMPLOY WELFARE RECIPIENTS

The Primary Contractor and a subcontracting BH-MCO shall make a good faith effort to outreach, train, and employ welfare recipients in accordance with the provisions of Appendix C.

I-10. INFORMATION CONCERNING SOCIALLY/ECONOMICALLY RESTRICTED BUSINESSES (SERB)

The Department strongly encourages the participation of SERBs.

SERBs are small businesses whose economic growth and development have been restricted based on social and economic bias. Such small businesses are BCABD certified minority- and women-owned businesses and businesses whose development has been impeded because their primary or headquarters facilities are physically located in areas designated by the Commonwealth as being Designated Enterprise Zones. A small business will not be considered socially/economically restricted if it has gross annual revenues exceeding \$4,000,000, is dominant in its field of operation, or employs more than 50 persons.

A company and its affiliates have achieved success and are graduated from this state sponsored program when their gross revenue exceeds \$4,000,000 annually. Any other small business, in which an owner(s) of a graduated firm has a financial interest or control over, either directly or through family members, will not qualify for SERB status. Control is defined as the power, whether or not exercised, to direct or cause the direction of the management and policies of a firm, whether through the ownership of voting shares, by contract or otherwise, or through the making of day-to-day as well as major decisions in matters of policy, management and operations. A determination of control shall include, but shall not be limited to, the following factors: capital investment and all other financial property, acquisition, contract negotiation, and legal matters; officer-director-employee selection and comprehensive hiring; operating responsibility; cost-control matters; income and dividend matters; financial transactions; and rights of other shareholders or joint partners.

I-11. CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS

The Primary Contractor certifies that it is not currently under suspension or debarment by the Commonwealth, any other state, or the federal government.

If the Primary Contractor enters into subcontracts or employs under this contract any subcontractors/individuals currently suspended or debarred by the Commonwealth or the federal government or who become suspended or debarred by the Commonwealth or federal government during the term of this Agreement or any extensions or renewals thereof, the Commonwealth shall have the right to require the Primary Contractor to terminate such subcontracts or employment.

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

The Primary Contractor may obtain the current list of suspended and debarred contractors by contacting the:

Department of General Services
Office of Chief Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone: (717)783-6472
FAX: (717)787-9138

The Primary Contractor agrees that the Commonwealth may offset the amount of any state tax liability or other debt of the Primary Contractor or its subsidiaries owed to the Commonwealth and not contested on appeal against any payment due the Primary Contractor under this or any other contract with the Commonwealth.

I-12. LOBBYING CERTIFICATION and DISCLOSURE

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. See Lobbying Certification Form attached as Appendix D and Disclosure of Lobbying Activities Form attached as Appendix E.

The Primary Contractor must complete and return the Lobbying Certification Form along with the signed Agreement.

I-13. PRIMARY CONTRACTOR RESPONSIBILITIES

The Primary Contractor is required to assume responsibility for all services offered in this document and Agreement whether it directly provides or subcontracts for the provision of the services. Further, the Department will consider the Primary Contractor to be the sole point-of-contact with regard to contract matters.

Where the Primary Contractor or BH-MCO subcontractor changes ownership or undergoes a major restructuring, including any major change to the submitted organizational chart or acquisition of another MCO, such change must be reported to the Department 30 days prior to the change or within 48 hours of confirmation of the change. Major organizational changes may result in the Department conducting a complete Readiness Review to assess continued adherence to the terms of the Agreement by the new structure. Continuation of the Agreement is contingent on a finding of the Readiness Review that the terms of the Agreement will be adhered to under the change/restructuring.

Office space, equipment, and logistical support are the responsibility of the Primary Contractor. The BH-MCO's administrative offices, from which the program is operated, must be located in close geographic proximity to the county or counties in which in-plan services are provided. If the Primary Contractor subcontracts the responsibilities of the Agreement, the Primary Contractor must assure the subcontractor meets the terms and requirements of the Agreement. All such subcontracts must be approved by the Department.

I-14. FREEDOM OF INFORMATION AND PRIVACY ACTS

Primary Contractos should be aware that all materials associated with a procurement are subject-ed to the terms of the Freedom of Information Act (5 U.S.C. Section 552 et seq.), the Privacy Act of 1974 (5 U.S.C. Section 552a), the Right-to-Know Law (65 P.S. Section 66.1 et seq.) and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, Health and Human Services (HHS), and Health Care Financing Administration (HCFA).

I-15. NEWS RELEASES

News releases pertaining to this project will not be made without prior Commonwealth approval, and then only in coordination with the Department.

I-16. COMMONWEALTH PARTICIPATION

The Department's Office of Mental Health and Substance Abuse Services (OMHSAS) provides the Project Office for a procurement and a formal oversight process for the ongoing program. The OMHSAS, in collaboration with the Department's Office of Medical Assistance Programs (OMAP) and the Department of Health's Bureau of Drug and Alcohol Programs (BDAP), provides responses to requests for clarification and questions. The Department will not provide office space, reproduction facilities, or other logistical support to any Primary Contractor.

The Department may provide requisite impartial review relating to behavioral health services for children and adolescents as well as a process for hearing Member appeals related to service denials.

The Department provides enrollment and disenrollment activities for the HealthChoices Program by contract as described in the Independent Enrollment Assistance Program RFP (HealthChoices Library).

I-17. PROJECT MONITORING

Project monitoring is the responsibility of the OMHSAS, in collaboration with OMAP and BDAP, and/or other offices, as well as consumers, persons in recovery and family members, as determined by the Department. Designated staff coordinate the project, provide or arrange technical assistance, monitor the Agreement for compliance with requirements, the approved waiver, and program policies and procedures.

In addition to Department oversight, HCFA may also monitor the HC Behavioral Health Services Program through its regional office in Philadelphia, Pennsylvania, and its Office of Managed Care in Baltimore, Maryland.

PART II. WORK STATEMENT – STANDARDS AND REQUIREMENTS

II-1. OVERVIEW

The goals of the HealthChoices physical and behavioral health care programs are to improve the accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases. The Department intends to achieve these goals by enrolling eligible MA recipients in PH-MCOs and BH-MCOs which provide a specified scope of benefits to each enrolled Member in return for a capitated payment made on a per Member per month basis.

II-2. OBJECTIVES

A. General

The Department is interested in working with counties and/or private sector BH-MCO's to administer the mandatory HealthChoices Behavioral Health Program within each county in the Commonwealth of Pennsylvania.

B. Specific Objectives

The HealthChoices Behavioral Health Program provides for the delivery of medically necessary mental health, drug and alcohol, and behavioral services. Specific objectives are:

1) Structure Objectives

- a. To contract with each of the counties in the HealthChoices area, individually or in county groupings, to manage the purchase and provision of behavioral health services in either one or more of the specified counties.
- b. To provide county government the option to directly manage the program through a county operated BH-MCO or to subcontract with a private sector BH-MCO. Such subcontracts do not relieve the county of ultimate responsibility for compliance with program and fiscal requirements, including program solvency. Counties may, however, include additional requirements and incentives in their subcontracts as needed to provide appropriate management oversight and flexibility in addressing local needs.
- c. For counties not able to or not interested in contracting for the managed care program, the Department will contract with a private sector BH-MCO to directly manage the purchase and provision of behavioral health services to Members.

2) Program Objectives

- a. To create systems of care management that are developed based on input from and responsive to the needs of consumers, persons in recovery, and their families representative of the various cultures and ethnic groups in the county, who depend on public services.
- b. To provide services that promote and support movement of Members toward independence and employment.
- c. To provide incentives to implement utilization management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care, and increasing prevention and early diagnosis and treatment.
- d. To promote partnerships between the public and private sectors that take advantage of the public sector's experience in serving persons with the most serious illnesses and disabilities who often have few resources and supports, and the private sector's expertise in managing financial risk for behavioral health services.
- e. To remove incentives to shift costs between behavioral health and other publicly funded human service and correctional programs.
- f. To create geographic service areas of optimal size for managing risk under capitation financing which allow for regional variations in program design and result in administrative cost savings.
- g. To develop consumer and family satisfaction mechanisms in partnership with consumers, persons in recovery, and their families representative of the diverse ethnic, cultural and disability groups in the county who are affected by mental illness and addictive diseases.
- h. To improve coordination of substance abuse and mental health services, including the development of specialized programs for persons with both psychiatric and substance abuse disorders.
- i. To create new integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children and adolescents.
- j. To shift the focus of state monitoring from process management to outcome management with an emphasis on reduction of out-of-home placements for children and adolescents, increased community tenure, improved health status, and improved vocational and educational func-

tioning.

- k. To accelerate the administration's state mental hospital rightsizing initiative.

II-3. NATURE AND SCOPE OF THE PROJECT

The HealthChoices Program ensures that enrolled MA recipients have access to quality physical and behavioral health services while allowing the Commonwealth to stabilize the rate of growth in health care costs. Primary Contractors for the behavioral health component of the HealthChoices Program are responsible for locating, coordinating, and monitoring the provision of designated behavioral health services on behalf of Members.

A. Enrollment Process

1) Enrollment Counseling

The Department contracts for the Independent Enrollment Assistance Program (IEAP) to provide enrollees with assistance in selecting and enrolling into a PH-MCO and with selecting a PCP. The IEAP is described in more detail in this document under Part II-5.C.2)

2) Enrollment

Enrollment for the HealthChoices PH-MCO project area is conducted simultaneously for counties in each zone.

a. HealthChoices Physical Health Care

Eligible MA recipients select a PH-MCO and a PCP with the assistance of the IEAP. An eligible MA recipient who does not select an HMO, even after receiving outreach efforts by the IEAP, is assigned a PH-MCO through an automatic assignment process.

b. HealthChoices Behavioral Health Care

Enrollment in a BH-MCO occurs simultaneously with a recipient's enrollment in a PH-MCO. No active selection is made by the recipient. Rather, recipients are notified of their enrollment in the BH-MCO operating in their county or residence upon enrollment (voluntary or assigned) in a PH-MCO. The BH-MCO must establish mechanisms to inform the County Assistance Office of any change or update to the Member's residency or eligibility status within 10 days of the date of learning of the change.

As recipients are enrolled in a specific PH-MCO and BH-MCO, information about the recipient is forwarded to the MCO's. The Department has sole authority for determining whether individuals or families meet eligibility criteria. The Department performs eligibility determinations using trained staff in County Assistance Offices (CAOs) located throughout the Commonwealth.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing behavioral health services for newly enrolled Members. The Department provides the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. The effective benefit start date typically occurs several weeks after enrolling in HealthChoices. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine periods of coverage and responsibility for services.

B. HealthChoices Program Eligible Groups

For purposes of this document, the HC Program population is defined to consist of seven different eligible groups, or aid categories. Qualification for the HC Program is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category in question. The scope of benefits and program requirements vary by the MA category. Should the Department choose to implement cost sharing options at a future date, these options may also be determined by MA category.

- 1) The seven eligible groups (see Appendix X for details) are:
 - a. Temporary Assistance to Needy Families (TANF) and TANF-Related MA: A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment), to families which contain dependent children who are deprived of the care or support of one or both parents due to absence, incapacity, or unemployment of a parent.
 - b. Healthy Beginnings: An MA program which covers children and adolescents born after September 30, 1983, and women during pregnancy and the postpartum period.
 - c. Healthy Horizons: An MA program which provides non-money payment (NMP) MA and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. Except-

tion: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC Program.

- d. SSI with Medicare: Monthly cash payments made to persons who are aged, blind, or determined disabled for over two years under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

SSI without Medicare: Monthly cash payments made to persons who are aged, blind, or have been disabled for less than two years and will become eligible for Medicare when the disability has lasted for two years, under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

- e. SSI-Related: An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.
- f. State-Only GA: A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.
- g. Federally-Assisted MA for GA Recipients: A federal and state funded program which provides MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

2) Eligibility Determination

The Department has sole authority for determining whether individuals or families meet any of the eligibility criteria specified in items a. through g. above. The Department performs eligibility determination using trained eligibility staff. These individuals are stationed at CAOs located throughout the Commonwealth.

3) Guaranteed Eligibility

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through the last day of the month in which the 60 days

postpartum or post-loss of pregnancy period ends and their newborns are guaranteed coverage for one year, as long as mother and child continue to live together during that year.

4) Involuntary Mental Health Commitment

Whenever a HealthChoices member residing in one HealthChoices county is made subject to involuntary examination and treatment in another HealthChoices county, the BH-MCO in the county in which the HealthChoices member resides shall be responsible for the cost of examination and involuntary treatment provided in the other county. The BH-MCO in which the HealthChoices member resides shall abide by the examination and involuntary treatment decisions made in the county in which services are rendered. The county BH-MCO where the member receives examination and/or treatment shall notify the member's BH-MCO within twenty-four (24) hours of commitment.

5) Placement of Adults and Children NOT in Substitute Care in Behavioral Health Residential Treatment Facilities

a. Inside the Zone to Outside the Zone:

- i) When the BH-MCO places a Member in a behavioral health residential treatment facility outside the HC zone, the BH-MCO retains responsibility for arranging, authorizing and paying for medically necessary behavioral health services to the Member. The Member reverts to the MA program in place in the county of placement for the provision of physical health care.
- ii) If a Member is placed in a behavioral health residential treatment facility outside the HC zone by a county court or behavioral health placement authority, such as the SCA, and the BH-MCO determines the placement is not medically necessary, the cost of care is the responsibility of the court and/or county placing authority, not the BH-MCO. If the placement results in a permanent change of county residence for purposes of determining HC program eligibility, the Member is disenrolled from both the HC physical and behavioral health programs.

b. Inside the Zone to Inside the Same Zone:

- i) When the BH-MCO places a Member in a behavioral health residential treatment facility outside the county, but within another county in the HC, the BH-MCO retains responsibility for arranging, authorizing and paying for medically necessary BH services to the Member. The Member also remains enrolled in

the HC PH-MCO for physical health care.

- ii) If a Member is placed in a behavioral health residential treatment facility outside the BH-MCO county, but within the HC zone by a county court or behavioral health placement authority, such as the SCA, and the BH-MCO determines the placement is not medically necessary, the cost of care is the responsibility of the court and/or county placing authority, not the BH-MCO. Whether or not the BH-MCO determines the placement to be medically necessary, the Member remains enrolled in both the HC PH and BH-MCOs.

c. Outside the Zone to Inside Zone:

MA recipients who reside in a county outside the HC zone who are placed in a behavioral health treatment facility located in the HC zone are not eligible for enrollment in the HealthChoices Behavioral Health Program. Such recipients are to be served through the MA Fee-for-Service program or, if placed in the facility by a BH-MCO from a different HealthChoices Program zone, remain enrolled in and are the payment responsibility of the placing BH-MCO.

d. Inside a HC Zone to Inside a Different HC Zone

- i) When a BH-MCO places a Member in a behavioral health residential treatment facility in a different HC zone, the Member remains enrolled in the HC placing zone BH-MCO, which retains responsibility for arranging, authorizing and paying for medically necessary behavioral health services to the Member. The Member enrolls in the PH-MCO in the different HC zone.
- ii) If a Member is placed in a behavioral health residential treatment facility in a different HC zone by a county court or behavioral health placement authority, such as the SCA, and the HC placing zone BH-MCO determines the placement is not medically necessary, the cost of care is the responsibility of the court and/or county placing authority, not the HC placing BH-MCO. If the placement results in a permanent change of county residence for purposes of determining HC program eligibility, the Member is disenrolled from the placing county BH-MCO and enrolled in the BH-MCO in the different HC zone county. The Member enrolls in the PH-MCO in the different HC zone.

6) Children in Substitute Care Issues

The BH-MCO will be required to pay for out-of-network medically necessary behavioral health care services for up to ten days for a child enrolled in its plan who

is placed in substitute care if the county C&Y agency cannot identify the child nor verify MA coverage. However, this out-of-network coverage will only be required in certain circumstances, such as emergency placement as determined by county child welfare or juvenile probation, or where the county C&Y agency has had no contact with the child prior to the placement. All efforts must be made by the county C&Y agency to identify the child and to determine MA coverage responsibility in the most expedient manner possible.

a Children in Substitute Care Placed in a Setting other than a Behavioral Health Residential Treatment Facility.

i) From Non-HC County to Inside a HC Zone

If a child in substitute care is determined eligible for MA in a non HC county, and is placed in a substitute care setting other than a behavioral health residential treatment facility, inside a HC zone, the child remains MA fee-for-service for their behavioral health services. The child is enrolled in the HC-PH-MCO for physical health services.

ii) From Inside the Zone to a Non-HC County

If a child in substitute care is determined eligible for MA inside a HC zone and is placed in a non-HC county, in a substitute care setting other than a behavioral health residential treatment facility, the child reverts to the MA program operating in the non-HC county for behavioral health services.

iii) From Inside the HC Zone to Inside the Same Zone

If a child in substitute care is determined eligible for MA inside the HC zone and is placed in a substitute care setting, other than a behavioral health residential treatment facility, in another county inside the zone, the child remains enrolled in the original county BH-MCO and PH-MCO.

iv) From Inside the HC Zone to Inside a Different HC Zone

If a child in substitute care is determined eligible for MA inside the HC zone and is placed in a substitute care setting, other than a behavioral health residential treatment facility, in a different HC zone, the child becomes MA fee-for-service for their behavioral health services. The child is enrolled in a PH-MCO serving the zone in which the child is placed.

b. Children in Substitute Care Placed in a Behavioral Health Residential Treatment Facility.

i) From a non-HC county to Inside the a HC Zone.

If a child in substitute care is determined eligible for MA in a non HC county and is placed in a mental health or drug and alcohol residential treatment facility inside the HC zone, s/he will remain

MA FFS for behavioral health services. The child is enrolled in the HC-PH-MCO for physical health care.

ii) From Inside the HC Zone to a non-HC county

a) Placement in a Mental Health Residential Treatment Facility:

If a child in substitute care is determined eligible for MA inside the HC zone and is placed in a mental health RTF in a non-HC county, the child remains enrolled in the HC BH-MCO. The BH-MCO is responsible for arranging, authorizing and paying for medically necessary behavioral health services. The child reverts to the MA program operating in the county for physical health care.

If a child in substitute care is determined eligible for MA inside the HC zone, but is placed in a mental health RTF in a non-HC county by a county placing authority or juvenile or adult court, and the HC zone BH-MCO determines the placement is not medically necessary, the cost of care is the responsibility of the court and/or the county placing authority, not the HC county BH-MCO. The child reverts to the MA program operating in the county for behavioral health care.

b) Placement in a Drug and Alcohol Residential Treatment Facility.

If a child in substitute care is determined eligible for MA inside the HC zone and is placed by either the BH-MCO or county placing authority in a drug and alcohol residential treatment facility in a non-HC county, the child reverts to MA FFS for behavioral health care. The county placing authority, not the BH-MCO, is responsible for the cost of drug and alcohol residential treatment. The county placing authority must work with their local SCA to determine payment responsibility for the drug & alcohol residential treatment costs. The child reverts to the MA program operating in the county for physical health services.

iii) From Inside the HC Zone to Inside the same HC Zone

a) Placement in a Mental Health Residential Treatment Facility

If a child in substitute care is determined eligible for MA inside the HC zone and is placed in a mental health RTF in another county inside the same HC zone, the child remains enrolled in the BH-MCO of the county from which the placement was made.

If a child in substitute care enrolled in a HC zone BH-MCO is placed in a mental health RTF within the same HC Zone

by a county placing authority or juvenile or adult court and the HC BH-MCO in which the child is enrolled determines the placement is not medically necessary, the cost of care is the responsibility of the county placing authority and/or the court, not the BH-MCO. The BH-MCO in which the child is enrolled remains responsible for arranging, authorizing and paying for medically necessary behavioral health services other than the RTF.

- b) Placement in a Drug & Alcohol Residential Treatment Facility
If a child in substitute care is determined eligible for MA inside the HC zone and is placed in a drug and alcohol residential treatment facility in another county inside the same HC zone, the child remains enrolled in the BH-MCO of the county from which the placement was made.

If a child in substitute care enrolled in a HC Zone BH-MCO is placed in a drug and alcohol residential treatment facility by a county placing authority or juvenile or adult court and the BH-MCO in which the child is enrolled determines the placement is not medically necessary, the cost of care is the responsibility of the county placing authority and/or the court, not the BH-MCO. The county placing authority must work with their local SCA to determine payment responsibility for the drug and alcohol residential treatment costs. The BH-MCO in which the child is enrolled remains responsible for arranging, authorizing and paying for medically necessary behavioral health services other than the RTF.

iv. From Inside a HC Zone to Inside a Different HC Zone

- a) Placement in a Mental Health Residential Treatment Facility
If a child in substitute care is determined eligible for MA inside the a HC zone and is placed in a mental health RTF in a different HC zone, the child remains enrolled in the HC placing BH-MCO. The child is enrolled in the PH-MCO serving the zone in which the child is placed.

If a child in substitute care enrolled in a HC Zone BH-MCO is placed in a mental health RTF in another HC Zone by a county placing authority or juvenile or adult court and the HC zone placing BH-MCO determines the placement is not medically necessary, the cost of care is the responsibility of the county placing authority and/or the court, not the BH-

MCO. The child reverts to the MA FFS program for behavioral health care.

b) Placement in a Drug and Alcohol Treatment Facility

If a child in substitute care is determined eligible for MA inside the a HC zone and is placed by either the BH-MCO or county placing authority in a drug and alcohol residential treatment facility in a different HC zone, the child reverts to MA FFS for behavioral health care. The county placing authority must work with their local SCA to determine payment responsibility for the drug and alcohol residential treatment costs. The child is enrolled in a PH-MCO serving the zone in which the child is placed.

- 7) For children and adolescents placed in a juvenile detention facility, the BH-MCO is responsible for medically necessary in-plan behavioral health services delivered in treatment settings outside (off site) the juvenile detention facility during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.
- 8) Children whose adoptions have been finalized and for whom the CCYA is continuing to provide support through an adoption assistance agreement with the adoptive parents residing in the HC zone, are to be enrolled in a the PH-MCO and in the BH-MCO of the county where the adoptive family resides.
- 9) Individuals in private ICFs/MR.

The BH/MCO will be required to pay for medically necessary behavioral health services for Members provided within a private ICF/MR facility within the HC-zone.

C. Rating Period

Capitation cost proposals apply to the initial rating period. For the second and third rating periods, the Department will adjust capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any or all of the following:

- 1) Changes in medical costs;
- 2) Changes in utilization patterns; or
- 3) Programmatic changes that affect the BH-MCO's delivery or coverage of benefits.

In the event that no adjustments are made, pursuant to C.1), 2) or 3) above, the rates applicable to the previous rating period will apply. The Department will disclose to the Primary Contractor the basis and assumptions of its determination with respect to adjustments to the second and third rating period rates.

If agreement is not reached prior to the start of an Agreement year, the rates applicable to the previous rating period will continue to apply for the remainder of the Agreement year.

If the Department exercises its option to renew the Agreement pursuant to Part I-4, rate negotiations will commence promptly after notice of same.

The Department reserves the right to expand the scope of the HealthChoices Program during the term of the Agreement to include additional services and will propose an Agreement amendment that will specify changes in the Department's compensation to the Primary Contractor when such changes are implemented.

D. Termination/Cancellation

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or waiver approvals, or change in applicable federal or Commonwealth law, regulation, public policy, or at the option of the Department.

Upon termination/cancellation or expiration of the Agreement, the Primary Contractor must:

- 1) Provide the Department with all information deemed necessary by the Department within 30 days of the request;
- 2) Be financially responsible for provider claims with dates of service through the day of termination, except as provided in D.3) below, including those submitted within established time limits after the day of termination;
- 3) Be financially responsible for Members placed in inpatient and residential treatment facilities through the dates specified in Section E of the HC BH Recipient Coverage document (Appendix V).
- 4) Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in D.3) above, for which payment is denied by the BH-MCO and subsequently approved upon appeal by the provider; and
- 5) Arrange for the orderly transition of Members and records to those providers who will be assuming ongoing care for the BH-MCO Members.

During the final quarter of the operational contract, the Primary Contractor and BH-MCO subcontractor will work cooperatively with, and supply program information to, any subsequent Primary Contractor. Both the program information and the working relationship between the Primary Contractors will be defined by the Department.

E. Compliance with Federal and State Laws, Regulations and Department Bulletins

The Primary Contractor and BH-MCO subcontractor must assure that network providers delivering in-plan services participate in the MA program and, in the course of such participation, provide those services essential to the care for individuals being served, and comply with all federal and state laws generally and specifically governing participation in the Medical Assistance Program. The BH-MCO and behavioral health service providers must also agree to comply with all applicable Department regulations and policy bulletins. The HealthChoices Library contains a copy of the laws, regulations and bulletins which govern the provision of services and supplies of the type furnished through the BH-MCO. Appendix BB identifies the portions of Departmental regulations and bulletins which are not applicable to the HC behavioral health program.

The Primary Contractor and its subcontractors must agree to comply with Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Section 2000 d. et seq. and 2000 e. et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq.); The Age Discrimination Act of 1975 (42 U.S.C. Section 6101 et seq.); Title II of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.) the Pennsylvania Human Relations Act of 1955 (71 P.S. Section 941 et seq.); The Pennsylvania Managed Care Consumer Protection Act (Act 68) of 1998 (Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2101 et seq.); as amended.

F. False Claims

The Primary Contractor recognizes that payments by the Department to the Primary Contractor will be made from federal and state funds and that any false claim or statement in documents or any concealment of material fact may be a cause for prosecution under applicable federal and state laws. Payments are contingent upon availability of state and federal funds.

G. Major Disasters or Epidemics

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, the Primary Contractor and a BH-MCO subcontractor shall require providers to render all services provided for in this document and the Agreement as is practical within the limits of providers' facilities and staff which are then available. The Primary Contractor and BH-MCO subcontractor shall have no obligation or liability for any provider's failure to provide services or for any delay in the provision of services when such a failure or delay is the direct or proximate result of the depletion of staff or facilities by the major disaster or epidemic.

H. Performance Standards and Damages

1) Performance Standards for the HC Behavioral Health Program

Performance standards for the HC Behavioral Health Program are included throughout this document. Additional standards may be developed, prior to the implementation of the Behavioral Health Program in a new zone, for inclusion in subsequent related Agreements.

2) Sanctions and Penalties

The Department may impose sanctions or penalties for non-compliance with, or failure to meet performance and program standards indicated in this document and/or subsequent related contracts.

Sanctions and penalties may be imposed by the Department in a variety of ways to include but not be limited to:

- a. Requiring the Primary Contractor to submit a corrective action plan.
- b. Imposing monetary penalties, including suspension or denial of payments.
- c. Terminating the Agreement.

3) Profit and Reinvestment Arrangement

- a. Counties as Primary Contractors are not permitted to retain any discretionary funds. After the closure of each Agreement year, any county discretionary funds which have not been included in a DPW approved reinvestment plan must be returned to DPW (Appendix N – Reinvestment Parameters).
- b. Private sector BH-MCOs as subcontractors to a county are permitted to retain profit in accordance with the terms of their contract with the Primary Contractor. Profit will be monitored by DPW and will be a factor in future DPW rate adjustments and negotiations with the Primary Contractor.

II-4. TASKS

A. In-Plan Services

The program includes medically necessary mental health, substance abuse and behavioral services.

- 1) The BH-MCO shall provide timely access to diagnostic, assessment, referral, and treatment services for Members for the following benefits:
 - a. Inpatient psychiatric hospital services, except when provided in a state mental hospital.
 - b. Inpatient drug and alcohol detoxification.
 - c. Psychiatric partial hospitalization services.
 - d. Inpatient drug and alcohol rehabilitation.
 - e. Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence.
 - f. Psychiatric outpatient clinic, licensed psychologist and psychiatrist services.
 - g. Behavioral health rehabilitation services (EPSDT) for children and adolescents with psychiatric, substance abuse or mental retardation disorders.
 - h. MH residential treatment services for children and adolescents (JCAHO accredited and non-JCAHO).
 - i. Outpatient D&A services, including Methadone Maintenance Clinic.
 - j. Methadone and LAAM (Levo-Alpha-Acetyl-Methadol) when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider.
 - k. Clozapine support services as well as laboratory and diagnostic studies and procedures ordered by behavioral health physicians.
 - l. Crisis intervention services (telephone and in-home capability).
 - m. Family-based mental health services for children and adolescents.
 - n. Targeted mental health case management (intensive case management and resource coordination).
 - o. Psychiatric rehabilitation services (site based and mobile programs) for adults.

- 2) The BH-MCO must have procedures for authorization and payment for covered services which are required but not available within the network or for providing emergency services for Members who are temporarily out of the service area.

- 3) The BH-MCO is encouraged to develop and purchase cost effective out-of-plan services and supplemental benefits which can provide services in a less restrictive setting and/or which would result in improved outcomes for consumers.

- 4) The BH-MCO must provide comprehensive service management, with clear access and lines of authority. Each Member's plan of care, including the commencement, course, and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination with services covered by the BH-MCO.

- 5) For priority populations, a clearly defined program of care which incorporates

longitudinal and disease state management is expected. In addition, evidence of a coordinated approach for those persons with co-existing mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with coexisting physical impairments, and other special needs populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities) must be demonstrated.

- 6) The BH-MCO is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and providers, and to provide screening and referral, as necessary.
 - a. There must be 24 hour capacity for service authorization.
 - b. There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
 - c. All Member and provider calls must be answered within 30 seconds.
 - d. Separate Member and provider telephone lines are permitted.
 - e. The Member line must be answered by a live voice at all times.
 - f. BH-MCOs serving multiple counties in a HC zone may establish a regional network with one telephone line for Member calls and one line for provider calls.
 - g. Separate record keeping must be established for tracking and monitoring of both provider and Member phone lines.

- 7) The BH-MCO must have procedures for reminders, follow-up, and outreach to Members including:
 - a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.
 - b. Population groups with special needs and/or groups who under use needed behavioral health services, such as older persons, persons who are homebound or homeless and adults with mental retardation.
 - c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

- 8) The BH-MCO must have procedures to determine the EPSDT screen status for children receiving behavioral health services. Referral to the child's PH-MCO PCP must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The BH-MCO must have procedures to collect and report EPSDT screen referral and status information.

B. Coordination of Care

- 1) The BH-MCOs and the PH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to recipients enrolled in the HealthChoices Program. These agreements must be submitted to and approved by the Department. The PH-MCOs and BH-MCOs in a HealthChoices Program project area are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. A sample coordination agreement (which does not include all required procedures) is in the HealthChoices Behavioral Health Library. Complete agreements, including operational procedures, must be available for review by the Department at the time of readiness review. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the HC program in a new zone. The written agreements should include, but not be limited to:
 - a. Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services, and other treatment issues necessary for optimal health and prevention of illness or disease. The PH-MCO and the BH-MCO must collaborate in relation to the provision of ER services; however, emergency services provided in general hospital emergency rooms are the responsibility of the Member's PH-MCO, regardless of the diagnosis or services provided. The only exception is for emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Member's primary diagnosis. Procedures must define and explain how payment will be shared when the Member's primary diagnosis changes during a continuous hospital stay.
 - b. Procedures, including prior authorization, which govern reimbursement by the BH-MCO to the PH-MCO for behavioral health service provided by the PH-MCO, or reimbursement by the PH-MCO to the BH-MCO for physical health services provided by the BH-MCO, and the resolution of any payment disputes for services rendered. Procedures must include provisions for assessment of persons with co-existing physical and behavioral health disorders, as well as provision for cost-sharing when both behavioral and physical health services are provided to a Member by a service provider.
 - c. Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PH-MCO, the primary care practitioner (PCP), and BH and PH service providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty providers).

- d. Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.
- e. Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources.
- f. A mechanism for timely resolution of any clinical and fiscal payment disputes; including procedures for entering into binding arbitration to obtain final resolution.
- g. Procedures for serving on interagency teams, as necessary.
- h. 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 and/or service provider(s) and the PH-MCO PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older adults with coexisting physical and behavioral health disorders).
- i. The BH-MCO is required to provide behavioral health crisis intervention and other necessary in-plan services to Members with behavioral health emergency medical conditions. The PH-MCO is responsible for payment of all emergency and medically necessary non-emergency ambulance services. The PH-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergency medical conditions who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities.
- j. Procedures for the coordination of laboratory services.
- k. Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and provider network with the PH-MCOs special needs unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO Quality Management program and the PH-MCO Quality Management program.
- l. Procedures for the PH-MCO to provide physical examinations required for the delivery of behavioral health services, within designated timeframes for each service.
- m. Procedures for the interaction and coordination of pharmacy services to include:
 - i) all pharmacy services are the payment responsibility of the Member's PH-MCO. All prescribed medications are to be dispensed through PH-MCO network pharmacies. This includes drugs prescribed by both the PH-MCO and the BH-MCO providers. The only exception is that the BH-MCO is responsible for the payment of methadone and LAAM when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service providers;

The PH-MCO may only restrict pharmacy services prescribed by a BH-MCO provider if one of the following exceptions is demonstrated:

- a) the drug is not being prescribed for the treatment of substance abuse/dependency/addiction or mental illness or to treat the side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's physical care health network;
 - b) the prescribed drug does not conform to standard rules of the pharmacy services plan; e.g., use of generic or cost effective alternative(s), purchases from certain pharmacies, and quantity limited to a 30 day supply;
 - c) the drug is prescribed by a behavioral health provider identified as not having a signed provider agreement with the BH-MCO; or
 - d) the prescription has been identified as an instance of fraud, abuse, gross overuse, or is contraindicated because of potential interaction with other medications.
- ii) BH-MCO representation on each HC PH-MCO's panel of physicians and other clinicians selecting the PH-MCO formulary. The PH-MCOs formularies or the reimbursable methods of administering drugs (e.g., use of injectibles) must be reviewed and approved by both OMAP and OMHSAS prior to program implementation and for any subsequent change;
 - iii) procedures for monitoring behavioral health pharmacy services provided by the PH-MCO;
 - iv) procedures for notifying each other of all prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records;
 - v) procedures for the timely resolution of any disputes which arise from the payment for or use of pharmaceuticals (e.g., use of anti-convulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when resolution between the PH-MCO and BH-MCO does not occur;
 - vi) procedures for sharing independently developed quality management/utilization management information related to pharmacy services, as applicable;
 - vii) policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations [Section 4401(g) of OBRA 1990, Section 4.26, guidelines 1927(g), 42

- CFR 456]; and
 - viii) procedures for the BH-MCO to collaborate with the PH-MCO in identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs. Areas for particular attention include potential and actual adverse drug reactions; therapeutic appropriateness; over and under drug use; appropriate use of generic products; therapeutic duplication; drug/disease contraindications; drug to drug interactions; incorrect drug dosage or duration of treatment; drug allergy reactions; and clinical abuse/misuse.
 - ix) The BH-MCO is required to provide the PH-MCOs with a listing of the physicians in its initial provider network and, on a quarterly basis, changes including terminations and additions.
- 2) The BH-MCO must ensure through its provider agreements that its providers interact and coordinate services with the HC PH-MCOs and their PCPs.

Both behavioral health clinicians and PCPs have the obligation to coordinate care of mutual patients. Consistent with state and federal confidentiality laws and regulations, both must:

- a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.
 - b. Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
 - c. Provide health records to each other, as requested.
 - d. Comply with the agreement between the BH-MCO and the PH-MCO to assure coordination between behavioral and physical health care including resolution of any clinical dispute.
 - e. Be available to each other for consultation.
- 3) The BH-MCO must establish procedures, which include referrals and interagency service planning, to coordinate in-plan service delivery with services delivered outside the scope of services covered by the BH-MCO:

- a. Supplemental Behavioral Health Benefits

In addition to the in-plan mental health, drug and alcohol and behavioral services listed in II-4 A.1), supplemental mental health and drug and alcohol services may be made available to Members pursuant to coordination agreements between the BH-MCO and the county mental health, mental retardation and drug and alcohol authorities. Supplemental services are not part of the capitated, in-plan benefit package. The

BH-MCO may, however, choose to purchase such services. At a minimum, the BH-MCO must facilitate access to and coordinate the following supplemental benefits, as available, for priority and special needs populations.

The supplemental benefits include:

- i) partial hospitalization for drug and alcohol abuse or dependence;
- ii) targeted D&A case management;
- iii) supported living services;
- iv) family education and support services; e.g., respite care;
- v) assistance in obtaining and retaining housing, employment, and income support services to meet basic needs;
- vi) continuous community based treatment teams;
- vii) adult mental health residential treatment (including long term structured residences and residential treatment facilities for adults);
- viii) community residential rehabilitation (CRR) services;
- ix) psychiatric rehabilitation services with in-home capability and clubhouses;
- x) consumer operated/directed self-help programs; e.g., drop-in centers, 12 step programs, double trouble groups;
- xi) D&A prevention/intervention services, including student assistance programs;
- xii) child/adolescent support groups; e.g., ALATEEN, peer groups;
- xiii) therapeutic recreation and companion programs; e.g., Compeer;
- xiv) drug and alcohol transitional housing;
- xv) drug and alcohol drop-in-centers; and
- xvi) drug and alcohol intensive outpatient services.

b. Medical Care

The Member's HealthChoices PH-MCO has a comprehensive benefit package provided in a manner comparable to the amount, duration, and scope set forth in the Medical Assistance Fee-for-Service program, unless otherwise specified by the Department. The comprehensive benefit package includes inpatient and outpatient hospital services, physician services, family planning services, prescription drugs, radiology, and other diagnostic and treatment services, outreach and follow-up, preventive care, home health services, and emergency transportation. Specific PH-MCO in-plan benefits include: EPSDT services; emergency room services; physical examinations to determine abuse or neglect; AIDS waiver program for MA eligibles; HIV/AIDS targeted case management; Healthy Beginnings Plus; medical foster care; medical services to HealthChoices Members, including Members placed in:

- i) intermediate care facilities for persons with mental retardation (ICF/MR), and intermediate care facilities for persons with other related conditions (ICF/ORC);
- ii) mental health residential treatment facilities (RTF);
- iii) acute and extended acute psychiatric inpatient facilities;
- iv) non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence; and
- v) juvenile detention facilities for up to 35 days.

All emergency room services in general hospitals are the responsibility of the Member's PH-MCO, regardless of the diagnosis or services provided except for evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act. Such evaluation is the responsibility of the BH-MCO pursuant to the terms of the written agreement described in II-4.B.1)a. Responsibility for ensuring admissions will be based on the Member's primary diagnosis.

All emergency and non-emergency medically necessary ambulance transportation for both physical and behavioral health services is the responsibility of the Members PH-MCO even when the diagnosis is provided by the BH-MCO.

c. Public Psychiatric Hospitalization

Civil and forensic psychiatric hospitalizations at a state mental hospital are not covered by the BH-MCO. However, the BH-MCO is expected to coordinate with the state mental hospital and county mental health authority, as applicable, to develop and implement admission and discharge planning to assure appropriate admissions and timely discharges and continuity of care for the Member.

- 4) The BH-MCO must enter into a written agreement with the county children and youth agency to include, at a minimum:
 - a. Procedures for referral, authorization and coordination of care, including overall requirements for children and adolescents in substitute care and specific requirements for referral, review of medical necessity prior to admission to and coordination of care following discharge from JCAHO and non-JCAHO RTF services, and D&A non-hospital residential rehabilitation and detox programs.
 - b. Liaison relationships for individual cases and administration.
 - c. Release of records and BH-MCO representation in court.
 - d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.

- e. Procedures to communicate denials of service by the BH-MCO.
 - f. Provision of BH-MCO provider directories, including electronic transmission where children and youth agency capacities exist.
- 5) For children and adolescents who are served by multiple child serving systems, the BH-MCO must:
- a. Have well publicized written policies and procedures explaining the BH-MCO is available to attend or convene interagency team meetings, at the request of or with the consent of the parent or custodian.
 - b. Treat as a formal request for service a prescriber's request for services pursuant to an interagency team recommendation, with the deadlines and grievance and appeal rights outlined in Appendix H, including the impartial review process for behavioral health rehabilitation and RTF services.
 - c. At the parent/custodian's or agency's request, serve on an interagency team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.
 - d. Coordinate specialized treatment plans for children and adolescents with special health needs.
- 6) The BH-MCO is required to coordinate service planning and delivery with human services agencies. The BH-MCO is required to have a letter of agreement with:
- a. Area Agency on Aging.
 - b. County Juvenile Probation Office (including the same components as the agreement with the county C&Y agency in II-4.B.4)).
 - c. County Drug and Alcohol agency, including:
 - i. A description of the role and responsibilities of the Single County Authority (SCA).
 - ii. Procedures for coordination with the SCA for placement and payment for care provided to Members in out-of-zone residential treatment facilities.
 - d. County offices of MH and MR, including coordination with the Health Care Quality Unit (HCQU).
 - e. Each school district in the county.
 - f. County and state criminal justice systems.
- 7) The BH-MCO must have in place written agreements with the other BH-MCOs in the HC zone to ensure continuity of care for Members who relocate from one HC county to another. The BH-MCO must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.

C. Member Services

- 1) The BH-MCO must provide Member services to include, but not limited to:
 - a. Explaining the operation of the BH-MCO.
 - b. Assisting Members to make appointments and obtain services including the explanation of procedures for accessing self-referred and prior authorized services.
 - c. Assistance in obtaining transportation through the Medical Assistance Transportation Program (MATP).
 - d. Handling Member complaints.
 - e. Explanation of rights.
 - f. Providing a list of current in-plan behavioral health network providers to the Member upon the Member's request.

The BH-MCO must provide each Member with the name of one individual in the program to be the Member's "point of contact" to explain plan services and assist the Member to access services.

2) Member Orientation

- a. In consultation with the Department, the BH-MCO must develop and distribute culturally/disability sensitive materials to Members regarding program features, policies, and procedures.
- b. The BH-MCO must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.
- c. The BH-MCO must publish and distribute a Member handbook, upon approval by the Department, to all Members and make it available to other interested parties upon request. The handbook must be printed at no higher than a fourth grade reading level, delineating a Member's rights and responsibilities, as well as covering:
 - i) a description of all available in-plan services and an explanation of any service limitations or exclusions;
 - ii) Act 68 required language, "this managed care plan may not cover all your health care expenses. Read your contract (handbook) carefully to determine which health care services are covered." Member services phone # _____.
 - iii) how to contact Member Services and a description of its function;
 - iv) how to use the complaint and grievances process;
 - v) no co-pay or cost sharing obligation by the Member;

- vi) procedures for choosing providers within a level of care;
- vii) instructions for obtaining care in an emergency;
- viii) how to obtain emergency transportation and non-emergency medically necessary transportation;
- ix) out-of-county/out-of-state moves or visits;
- x) explanation of the procedures for accessing behavioral health services, including self-referred and prior authorized services;
- xi) confidentiality protections, including access to clinical records by oversight agencies and through the quality assurance/utilization management program;
- xii) information concerning methods for coordinating services for Members;
- xiii) how to obtain MATP services;
- xiv) include phone numbers of the clinical sentinel and BH advocacy agencies.

- 3) The BH-MCO must develop and implement programs for public education and prevention including behavioral health education materials and activities.

Public education programs shall focus on prevention, available services, leading causes of relapse, hospitalization and emergency room use, and shall address initiatives which target high risk population groups.

D. Member Disenrollment

- 1) General Authority

The Department has sole authority for terminating a HealthChoices Member from a HealthChoices PH-MCO or BH-MCO, subject to the conditions described below.

- 2) Reasons for Disenrollment

The Department may terminate a Member from the BH-MCO on the basis of:

- a. Member's loss of Medical Assistance eligibility.
- b. Placement of the Member in a nursing facility for more than 30 consecutive days.
- c. Placement in any state facility, including a state psychiatric hospital, other than a state operated ICF/MR.
- d. Placement in a juvenile detention center for more than 35 consecutive days.
- e. Change in permanent residence of the Member which places the Member outside the BH-MCO's service area.
- f. Change in status to a recipient group which is exempt from the HC Pro-

- g. Determination by the Department to be eligible for the Health Insurance Premium Payment Program (HIPPP).
- h. Becoming ventilator-dependent in an acute or rehabilitation hospital for more than 30 consecutive days.
- i. Enrollment in the Pennsylvania Department of Aging (PDA) waiver.
- j. Enrollment in the Michael Dallas Model waiver.

- 3) The BH-MCO shall not terminate any Member from the HC Behavioral Health Program.
- 4) A Member's termination from enrollment becomes effective on a date specified by the Department. The BH-MCO is expected to have policies and procedures to comply with any Department enrollment termination orders and for the Member's continuity of care as described in II-4.B.7).

E. Complaint and Grievance System

1) General

The BH-MCO must establish complaint and grievance mechanisms through which Members and providers can seek redress against the BH-MCO. The BH-MCO may not take any adverse action against a provider for assisting a Member in the understanding of or filing of a complaint or grievance under the Member complaint and grievance system.

Primary Contractors may impose additional requirements on BH-MCO subcontractors as are deemed appropriate for effective management.

2) Member Complaint and Grievance System

The BH-MCO must develop, implement, and maintain a complaint and grievance system which provides for settlement of Member complaints and grievances at the most efficient administrative level. The complaint and grievance system must conform to the conditions set forth in Appendix H.

- a. The BH-MCO must provide enrollees/Members and parents/custodians of children and adolescents (for children in substitute care, both parents , if whereabouts are known and county C&Y agency must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a complaint or grievance and/or to request a DPW Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a complaint or grievance.
- b. The BH-MCO must ensure that any subcontractor, with authority to ap-

prove and disapprove service requests, complies with the complaint and grievance procedures and reporting requirements established by the BH-MCO.

- c. Denials of service or coverage must be in writing, notifying the Member or parent/custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a grievance and/or request a DPW Fair Hearing and the process for doing so.
- d. The BH-MCO is expected to integrate its complaint and grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.
- e. The BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in complaints and grievances.
- f. The BH-MCO must provide all required Member complaint and grievance information to the Independent Enrollment Assistance Program.
- g. The BH-MCO's grievance system may not be a prerequisite to or replacement for the Member's right to appeal to the Department of Public Welfare (in accordance with 42 CFR 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the BH-MCO. The BH-MCO must cooperate with and adhere to the Department's procedures and decisions.
- h. Complaints or grievances concerning the Recipient Restriction Program must be directed to the Office of Medical Assistance Programs, Bureau of Program Integrity, for resolution.
- i. Complaints or grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/HCFA's Office of Inspector General, and the United States Justice Department.

3) Denial of Services

The BH-MCO must have a procedure that allows Members to grieve denials of requests for authorization for services. Individuals responsible for denying services or reviewing grievances of denials, must have the necessary and appropriate clinical training and experience. All denials must be made by a physician or, in some cases, by a licensed psychologist. Denials of inpatient care must be approved by a physician. Qualifications of individuals must be consistent with Appendix H, and all applicable Commonwealth laws and regulations.

If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an urgent or emergency service, the BH-MCO must have a process for expedited review of such grievances to occur within 24 hours of the request.

Any time the BH-MCO denies a request for authorization for service, the BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:

- i) Specific reasons for the denial with references to the program provisions;
- ii) A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.
- iii) A description of the Member's right to file a grievance and/or request a DPW Fair Hearing.
- iv) Information for the Member describing how to file a grievance and/or request a DPW Fair Hearing.
- v) An offer by the BH-MCO to assist the Member in filing a grievance and/or DPW Fair Hearing.

4) Provider Complaint System

The BH-MCO must develop, implement and maintain a provider complaint system which provides for informal mediation and settlement of provider complaints at the lowest administrative level and a formal complaint process when informal resolution is not possible.

The provider complaint system must demonstrate a fundamentally fair process for providers; adequate disclosure to providers of provider rights and responsibilities at each step of the process; and sound and justified decisions made at each step.

The Department's Bureau of Hearings and Appeals is not an appropriate forum and shall not be used by providers to appeal decisions of the BH-MCO.

II-5. REQUIREMENTS

The Primary Contractor is responsible for administering a behavioral health managed care program which meets, at a minimum, the requirements outlined below. The standards allow flexibility in the approach to meeting program objectives, while ensuring the needs of Members are met.

A. General

Participation will be limited to Primary Contractors who are either counties or private

sector BH-MCOs licensed by the Commonwealth as an HMO or a risk assuming PPO with operating authority for the covered county/counties. A county operated BH-MCO established as an arm or branch of county government is not subject to licensure, so long as the county maintains responsibility for all financial risk. If the county establishes the BH-MCO as a separate risk assuming entity, then the BH-MCO must meet the same licensing requirements as a private sector BH-MCO. A county operated BH-MCO established as an arm or branch of county government must be certified by the Commonwealth as a Certified Utilization Management entity under Act 68 if it directly performs utilization management functions. In the event a joinder or other county grouping submits a single proposal, each county must be separately responsible for financial risk. One county may not assume the financial risk of the other county(ies) covered by the proposal

B. Executive Management

- 1) The development of the behavioral health managed care program is a broad based process. The Primary Contractor must have documentation of the participation of consumers, persons in recovery and family Members, including parents of children and adolescents, as well as county drug and alcohol, mental health and mental retardation, children and youth, juvenile justice, and Area Agency on Aging programs and school districts in the development of the behavioral health managed care program. Participation must include the involvement of consumers, persons in recovery, and family members in the selection of a BH-MCO subcontractor if one is used and development of the proposal in response to the Department's document. Consumers, persons in recovery and family members must also be involved in ongoing program oversight.
- 2) In the event a county is the Primary Contractor, the county (separate from the BH-MCO) must establish an administrative structure for management and program oversight of the behavioral health managed care program. The management structure must include clearly defined and assigned responsibility for monitoring the BH-MCO's fiscal, program/quality assurance and management information systems.
- 3) Primary Contractors and their subcontracting BH-MCOs are required to place all HealthChoices capitation payments in a separate, restricted account(s).
- 4) County Primary Contractors are required to place reinvestment funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DPW. Primary Contractors must have prior approval from DPW to carryover reinvestment funds from one Agreement year into a subsequent Agreement year; however, DPW approved reinvestment plan funds must continue to be tracked separately. Counties can maintain reinvestment funds, for DPW approved reinvestment plans, up to six (6) months after the time period delineated in their approved reinvestment plan, unless such date is

otherwise extended by the Department. This includes reinvestment plans that cover more than one (1) year. After that time, unexpended reinvestment funds must be returned to the Department. The reinvestment spending plans for carryover funds are due to DPW three months prior to the closure of each Agreement year. Any funds remaining in the reinvestment account at the time of Agreement termination must be returned to DPW.

- 5) The BH-MCO may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:
 - a. A Chief Executive Officer with clear authority over the entire operation of the BH-MCO.
 - b. A Medical Director who is a board certified psychiatrist licensed in the Commonwealth with at least five years combined experience in mental health and substance abuse services. The responsibilities of the Medical Director include:
 - i) development of clinical practice standards, policies, procedures, and performance;
 - ii) review and resolution of quality of care problems;
 - iii) participation in complaint and grievance processes related to service denials and clinical practice;
 - iv) development, implementation, and review of the internal quality management and utilization management programs;
 - v) oversight of the BH-MCO's referral process for specialty and out-of-plan services;
 - vi) oversight and management of the BH-MCO's behavioral health rehabilitation and residential services for children and adolescents, in collaboration with the HealthChoices PH-MCO's Medical Directors;
 - vii) leadership and direction in the BH-MCO's clinical staff recruitment, credentialing, and privileging activities;
 - viii) leadership and direction in the BH-MCO's prior authorization and utilization review processes;
 - ix) leadership and direction of policies and procedures relating to confidentiality of clinical records; and
 - x) participation in any meetings called by the Department.
 - c. A Chief Financial Officer (or governmental equivalent) to oversee the budget and accounting system.
 - d. Quality Management
 - e. Utilization Management.
 - f. Management Information Systems
 - g. Prior Authorization to include:
 - i) assessment and substantiation of need for psychiatric and be-

gram by the BH-MCO must have the Department's prior, written approval. The BH-MCO will be required to print and provide the IEAP with an adequate supply of approved materials on a continual basis.

The BH-MCO must have mechanisms to receive information via POSNet from the IEAP regarding the special needs and special services required by Members, identified at the time of enrollment. Record layouts and file specifications are located in the HealthChoices Library.

3) Recipient Restriction Program

The Department maintains a program for any recipient who is identified as over-using and/or misusing Medical Assistance services. The restriction process involves an evaluation of the degree of abuse, a determination as to whether or not the recipient should be restricted, notification of the restriction, evaluation of subsequent MA services use, and removal from the restriction after a period of five years (per current HCFA regulations) if improvement in use of services is demonstrated.

The BH-MCO must comply with the Department's Recipient Restriction Program administered by the OMAP, Bureau of Program Integrity (BPI); provide for appropriate professional resources to identify and monitor Member abuse; perform the necessary administrative activities to maintain accurate records; comply with federal guidelines; and carry out all procedures necessary to restrict Members who are misusing physical or behavioral health services, including pharmacy benefits.

4) Training and Professional Development

The BH-MCO must provide an ongoing process of training and professional development for BH-MCO Member services, service management, quality assurance and utilization management staff. Training topics should include but not be limited to: CSP and CASSP principles and BDAP treatment philosophy, Member rights, complaint and grievance process, provider network access, human services, current clinical practice needs of special populations including persons with co-occurring mental health drug & alcohol conditions, persons with mental retardation, children in substitute care and/or in juvenile probation, school intervention services, and medical necessity criteria including the ASAM and PCPC.

5) The BH-MCO must monitor the performance and quality of service of any BH services providers to which work is delegated to assure conformance with the terms of the Agreement with the Department.

6) The BH-MCO must work in partnership with the designated county/municipal

health department, and primary care practitioner as applicable, to ensure that conditions identified in accordance with Chapter 25, Disease Prevention and Control Law (35 P.S. § 521.1 et seq.) are reported (e.g., tuberculosis, hepatitis).

7) Records Retention

a. General

The Primary Contractor, subcontracting BH-MCO and BH services providers must agree to maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files.

The Primary Contractor, subcontracting BH-MCO and BH services providers also must agree to comply with all standards for record keeping specified by the Commonwealth. Operational data and medical record standards are described below, and complete standards are available in the HealthChoices Library.

The Primary Contractor, subcontracting BH-MCO and BH services providers must, 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 regular business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.

The Primary Contractor, subcontracting BH-MCO and BH services providers 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 their original form. Financial books, records, documents, and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives up to five years after the date of the last payment under the Agreement, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all work is completed.

b. Operational Data Reports

The Primary Contractor and subcontracting BH-MCO must agree to retain the source records for its data reports for a minimum of seven years and must have written policies and procedures for storing this information.

c. Clinical Records

The Member's clinical record is the property of the provider who generates the record. The BH-MCO must have written policies and procedures to maintain the confidentiality and provide Member and other requesting entities access to the record, consistent with applicable state and federal confidentiality requirements. The Commonwealth must be afforded prompt access to all Members' clinical records whether electronic or paper.

The BH-MCO must have written policies and procedures for the maintenance of clinical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to Members. Therefore, the BH-MCO must have written standards for clinical record documentation which reflect legibility, accuracy, completeness, and that chronologically reflect the evaluation, appropriateness of treatment, and medical necessity within the plan of care for the Member. A complete list of standards to follow are contained in MA Chapter 1101 general regulations and the HealthChoices clinical record components document located in the HealthChoices Library.

Clinical records must be legible, signed, dated, preserved, and maintained for a minimum of five years from expiration of the Agreement. Clinical records must be maintained in paper form for at least two years before conversion to any other form and records in all forms must be readily available for review.

The Department is not required to obtain written approval from a Member before requesting the Member's clinical record from the BH-MCO or any other provider, consistent with state and federal confidentiality requirements.

D. Provider Network/Relations

- 1) The BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The network must have the following features in place and documented:
 - a. Sufficient provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a provider(s) within each level of care.
 - b. Represent the cultural and ethnic diversity of Members and their neighborhoods.
 - c. Clinical expertise and cultural competency in responding to Members with special needs.
 - d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance abuse disorders among older adults (particularly those with co-existing medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS.
 - e. Inclusion of providers trained and experienced in working with the priority and special needs populations covered under the plan.
 - f. Evidence of a cooperative relationship between the BH-MCO and its provider network, for example, inclusion of providers by the BH-MCO in the development of clinical protocols and provider profiling.

- 2) The BH-MCO must manage the provider network through agreements which include the following provisions:
 - a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.
 - b. Criteria for provider's clinical privileges, as applicable.
 - c. Clinical performance standards and data reporting requirements.
 - d. Financial performance standards and data reporting requirements.
 - e. Complaint procedures for providers.
 - f. Requirements for referral, coordination of treatment planning, and consultation (including participation during interagency team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.
 - g. Requirements for coordination and continuity of care of behavioral health services with social services; e.g., mental retardation, area agencies on aging, juvenile probation, housing authorities, schools, child wel-

- h. fare, juvenile and county and state criminal justice. Requirements for coordination, credentialing, and continuity of care with PH-MCOs and PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).
 - i. Procedures for approving demonstration projects for in-plan service and treatment alternatives/innovations.
 - j. Compliance with Act 33 (Child Protective Services Law 23 Pa. C. S. § 6301 et seq.) clearance for all individuals working with children and adolescents. Criminal background checks if required.
 - k. Compliance with Act 13 (Older Protective Services Law) background checks for working with older persons.
 - l. Authorization of in-plan services in accordance with DPW approved medical necessity criteria and prior authorization procedures.
 - m. Assurance that providers delivering in-plan services to Members via a subcontractual arrangement with a network provider, meet the same requirements and standards as a network provider.
 - n. Procedure to provide access to client records for quality of care and access reviews.
- 3) The BH-MCO must have policies and procedures to monitor that the access standards are met by each provider in each level of care. The BH-MCO must monitor the network to assure that providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.
 - 4) The BH-MCO must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis. The BH-MCO must make incident records and reports immediately available to the Department upon request.
 - 5) The BH-MCO must maintain procedures for immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OMAP, Bureau of Program Integrity.
 - 6) The BH-MCO must notify the Department promptly of any changes to the composition of its provider network that affect the BH-MCO's ability to make available all covered services or respond to the special needs of a Member or population group in a timely manner.
 - 7) The BH-MCO must maintain a plan of orientation and ongoing training for network providers. Training shall include but not be limited to:

CASSP and CSP principles and BDAP treatment philosophy; priority

and special need population issues such as children in substitute care and/or juvenile probation; prior authorization of services; continuity of care; payment procedures; complaint and grievance rights and procedures; coordination requirements with PH-MCOs and PCPs; coordination requirements with county behavioral health and human services systems; current clinical best practice and community service resources and advocacy organizations.

E. Provider Enrollment - Credentialing/Recredentialing

- 1) In maintaining the provider network, the BH-MCO must have credentialing and recredentialing criteria for all in-plan provider types as well as for providers of supplemental and alternative services in the BH-MCO provider network. Criteria must include, but not be limited to:
 - a. Applicable license or certification as required by Pennsylvania law.
 - b. Verification of enrollment in good standing with Medicaid (Providers of alternative and supplemental services must be enrolled in the MA program pursuant to procedures in Appendix Z).
 - c. Verification of an active MA provider agreement.
 - d. Evidence of malpractice/liability insurance.
 - e. Disclosure of any past or pending lawsuits/litigations.
 - f. Board certification or eligibility, as applicable.

F. Service Access

- 1) The BH-MCO provider network must provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for urgent situations, and within seven days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the start date and frequency of treatment services.

The BH-MCO must have a notification process in place with providers for the referral of a Member to another provider, if a selected provider is not able to schedule the referred Member within the access standard.

- 2) The BH-MCO must maintain a provider network which is geographically accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the Member travels is at least two (2) providers for each in-plan service:
 - a. Within 30 minutes travel time in urban areas.
 - b. Within 60 minutes travel time in rural areas.

The access standard for inpatient and residential services is at least two providers for each in-plan service, one of which must be:

- a. Within 30 minutes travel time in urban areas.
- b. Within 60 minutes travel time in rural areas.

The access standard for in plan crisis intervention services (telephone and mobile) is a minimum of one provider.

Network providers are not required to be located within the county covered by the Agreement. Adherence to the travel time requirements may in fact be facilitated by the BH-MCO's inclusion of out-of-county BH services providers in its network.

The BH-MCO must obtain DPW approval for policies and procedures to cover situations in which the MCO determines that a Member is in need of a specialized in-plan service and a provider is not available within the travel timeframes. The policy and procedures shall ensure the appropriate delivery of services and the availability of local supports for the Member.

- 3) The BH-MCO must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process in accordance with Appendix T for admission, continued stay and discharge for all in-plan services. The BH-MCO's service authorization system must include procedures for informing providers and Members of authorization decisions.
- 4) The BH-MCO must have written policies and procedures which comply with MA Bulletin 99-96-01 and Appendix V, to authorize care and transition Members to network providers for Members who are in care at the time of the Agreement implementation. (Note, Bulletin 99-96-01 is specific to continuity of prior authorized services for Members under age 21. A Bulletin detailing the continuity of care requirements applicable to prior authorized services for adult Members as well as non-prior authorized services for all Members will be issued in the near future.) Policies and procedures must specifically address priority and special needs populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or providers must also be included. Where disruption of services would have a significant negative impact on the Member, the BH-MCO must have provisions for the authorization and payment of services delivered by out-of-network providers. A transition monitoring plan must be developed to ensure that procedures and protocols governing transition into service are being followed and that transition problems are identified and corrected. The transition plan should also address BH-MCO staff recruitment and training prior to start-up and supervisory support during initial implementation. Planning must also address network provider credentialing, contracting and training; BH-MCO telephone capacity related to both Member services and service manage-

ment functions; and MIS backup.

- 5) The BH-MCO must have procedures for accessing out-of-network, but in-plan, services in emergency or unique situations including services for children and adolescents in substitute care.
- 6) The BH-MCO must have procedures to assure continuity of care for Members affected by either provider termination or loss of the Member's MA eligibility when medical necessity continues at the same or other level of care.
- 7) If 5% or more of the MA recipients in a County Assistance Office or a District Office within the county speak a language other than English as a first language, the BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy provider directories, education and outreach materials, marketing materials, written notifications, etc. Interpreter services must be available, as practical and necessary, by telephone and/or in person to ensure Members are able to communicate with the BH-MCO and providers, and receive covered benefits in a timely manner.

In addition, the BH-MCO must comply with the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq.) concerning the availability of appropriate alternative methods of communication for Members who are visually impaired, deaf or hard of hearing. Such appropriate alternative methods include, but are not limited to, Braille, audio tapes and/or computer diskettes. The BH-MCO must provide Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication Relay Services for communicating with Members who are deaf or hard of hearing, and comply with the ADA concerning access for Members with physical disabilities.

- 8) The BH-MCO is expected to refer any Member in need of any routine and specialized medical and/or social service not provided by the BH-MCO to an appropriate agency/organization.
- 9) The BH-MCO and its provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa. C.S. Section 6311.
- 10) The BH-MCO must assure that Members are provided reasonable access to behavioral health services provided by Federally Qualified Health Clinics (FQHC), wherever FQHC behavioral health services are available, within travel of 30 minutes (urban) and 60 minutes (rural).

G. Utilization Management and Quality Management (UM/QM)

1) General

COMMONWEALTH OF PENNSYLVANIA

HealthChoices Behavioral Health Program

Program Standards and Requirements - Primary Contractor - County

May 1, 2001

Page 46

The BH-MCO must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

- a. Conform to state Medicaid plan quality management requirements.
- b. Assure a UM/QM Committee meets on a regular basis.
- c. Provide for regular UM/QM reporting to the BH-MCO management and its provider network (including profiling of provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the HealthChoices PH-MCOs.
- d. Provide opportunity for consumer (including representation for consumers in special needs populations), persons in recovery and family (including parents/custodians of children and adolescents) participation in program monitoring.

2) Utilization Management (UM)

The BH-MCO must have Department approved written utilization management policies and procedures that include protocols for prior approval (in accordance with Appendix AA), determination of medical necessity, concurrent review, denial of services, hospital discharge planning, provider profiling, and retrospective review of claims. As part of its utilization management function, the BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

Utilization management practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of behavioral health services, procedures, and use of facilities.

The BH-MCO is required to have criteria and review procedures. Mental health review criteria must be compatible with guidelines provided in Appendix T. Drug and alcohol reviews must be conducted in accordance with the Pennsylvania Client Placement Criteria for adults issued by the Department of Health and for children and adolescents, with criteria compatible with those of the American Society of Addiction Medicine. The BH-MCO will distribute the review and utilization management criteria to all providers in its provider network and to any new provider who signs a provider agreement with the BH-MCO. The BH-MCO must also provide the criteria to Members, upon request.

3) Quality Management (QM)

The BH-MCO must have a written quality management (continuous quality improvement) plan to monitor, assure, and improve the quality of care delivered

over a range of clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, high volume and high risk services and treatment and behavioral health rehabilitation services for children and adolescents.

As a part of the quality management plan, the BH-MCO should address, at a minimum, the effectiveness of the services received by recipients, the quality and effectiveness of internal processes, and the quality of the provider network. Among those areas to be considered in service delivery are access to services, the appropriateness of service manager authorizations, the authorization appeal process, adverse incidents, and the quality of service manager planning. Internal processes include but are not limited to telephone responsiveness; overall utilization patterns and trends; treatment outcomes; and complaint, grievance and Fair Hearing tracking processes. Provider monitoring includes but is not limited to utilization patterns, treatment outcomes, cooperation, and Member satisfaction. The QM plan shall also include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

4) Confidentiality

The BH-MCO must have written policies and procedures which comply with federal and state law and regulations for maintaining the confidentiality of data, including clinical records/Member information.

5) Member Satisfaction

The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (in accordance with Appendix L) providing for face-to-face discussions with consumers and family members as a means for early identification and resolution of problems related to service access, delivery and outcome as well as an annual survey of Member satisfaction for a representative sample of the HealthChoices Member population. The annual survey may be conducted by mail or through structured face-to-face interviews with Members and their families, or both. An annual report must be submitted to the Department on the activities and findings of the Consumer/Family Satisfaction Teams and member satisfaction survey. Members and their families, including parents of children and adolescents who are seriously emotionally disturbed and/or who abuse substances, are to participate on the consumer/family satisfaction teams and in the design and implementation of the survey process. Such participation is to include: serving on consumer/family satisfaction teams, the review of consumer/family satisfaction team and annual survey findings, and the determination of quality improvements to be

undertaken based on the findings. The Primary Contractor and any subcontracting BH-MCO should also have mechanisms which ensure that Member comments concerning provider performance can be tracked in aggregate and be used as a component of provider profiling. In addition, the Primary Contractor and subcontracting BH-MCO must cooperate in Member satisfaction assessments which may be performed by the Department, independent of the BH-MCO's internal process.

6) Provider Satisfaction

The Primary Contractor, either directly or via a BH-MCO or other subcontractor, must have systems and procedures to assess provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual provider satisfaction survey. Areas of the survey must include claims processing, provider relations, credentialing, prior authorization, service management and quality management.

7) Department Review

The Primary Contractor, BH-MCO subcontractor and BH services providers must agree to make available to the Department and/or its authorized agents, on a periodic basis, clinical and other records for review of quality of care and access issues.

8) External Independent Assessment

The Primary Contractor, BH-MCO subcontractor and BH services providers must agree to cooperate fully with external evaluations and assessments of its performance under the Agreement authorized by the Department. Independent assessments will include, but not be limited to any independent evaluation required or allowed by federal or state statute or regulation or by the Department.

The Primary Contractor, BH-MCO subcontractor and BH services providers must agree to assist in the identification and collection of any data or clinical records to be reviewed by the independent evaluation team Members. The Primary Contractor and BH-MCO subcontractor must ensure data, clinical records, and work space are available to the independent review team and to the Department upon request and at the BH-MCO's work site.

The Primary Contractor must submit a corrective action plan, as determined by the Department, to resolve any performance or quality of care deficiencies identified as a result of the independent evaluation and/or by the Department.

II-6. PROGRAM OUTCOMES AND DELIVERABLES

A. Outcome Reporting

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the Primary Contractor and a subcontracting BH-MCO must comply with the Department's program performance reporting requirements as delineated in Appendix K and as further defined by the HealthChoices Outcome Measures Advisory Group. An expanded working draft version of Appendix K (HealthChoices Performance Outcome Management System) is included in the HealthChoices Library. The Primary Contractor must establish all coordination agreements and procedures necessary to collect the required data elements from the providers, Members, etc.

The Primary Contractor and a subcontracting BH-MCO must provide quarterly reports summarizing the findings, and actions taken in response to the findings of the consumer/family satisfaction teams as well as an annual report summarizing the findings and follow-up actions taken pursuant to the annual Member satisfaction survey conducted pursuant to Appendix L.

The Primary Contractor must have a plan in place to review the BDAP CIS data for accuracy and completeness and a plan to work with their providers to that end.

B. Deliverables

Deliverables submitted by Primary Contractors include, but are not limited to:

- 1) Member Services Marketing materials; Member handbooks; educational materials; complaint and grievance policies and procedures; prior authorization and access policies and procedures; listing of providers.
- 2) Administration Letters of agreement; provider contracts/subcontracts; provider complaint system procedures; provider network; staff development plan; provider directory; provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral form; coordination agreements; complaint and grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and regulations.
- 3) Quality Management /Utilization Management

QM plan; reports of QM activities; procedures for sharing independently developed QM/UM information related to pharmacy services; UM criteria and review procedures; clinical records and Member information;

and corrective action plan(s).

- 4) Data Descriptions of management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; complaint and grievance reports; performance outcome management reports, including the Consumer Registry and Quarterly Status; transition monitoring and monitoring reports.
- 5) Behavioral Health Rehabilitation Services for Children and Adolescents
Procedures for informing Members and providers about services available pursuant to the BHRS program; procedures for evaluating provider compliance with BHRS requirements; procedures for ensuring timely provision of services on an emergency or urgent basis.
- 6) Other Organization chart listing key staff/functions; management information system; management and financial data system; identification and location of service sites; plan for coordination with county mental health and drug and alcohol authorities, as applicable; coordination agreement including procedures for clinical dispute resolution between the PH-MCO and BH-MCO; DUR policies and procedures; incident reports and trend analyses.

II-7. FINANCIAL AND REPORTING REQUIREMENTS

A. Financial Standards

To measure the program's capacity to assume and manage risk as well as meet fiscal requirements related to account management and claims processing, the Primary Contractor and its BH-MCO subcontractor, if applicable, must provide the Department with financial reports as requested and on a regular basis. It must also cooperate with any Department or external, independent assessment of performance under the Agreement, including any federally required cost-effectiveness review or other audit.

1) General

The Insurance Department (ID) regulates the financial stability of licensed BH-MCOs in Pennsylvania. Any BH-MCO, therefore, must comply with applicable Insurance Department standards in addition to standards described in this document.

2) Risk Protection for High Cost Cases

The Department seeks to minimize risks that valid claims, submitted to BH MCOs by providers, for costs incurred by a recipient above a certain monetary threshold, might not be paid. Each Primary Contractor must have a risk protection arrangement in place until the Agreement expires. This risk protection arrangement must include individual stop loss reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one (1) Member during one (1) year in excess of \$75,000. The Department may alter or waive the reinsurance requirement if the Primary Contractor submits an alternative risk protection arrangement that the Department determines is acceptable.

The Department reserves the right to institute a different reinsurance threshold amount, to be determined by the Department, if, upon review of financial and encounter data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by DPW. A review will occur annually, so that any change in reinsurance thresholds can be imposed or withdrawn as the financial situation of the Primary Contractor warrants a change.

The Primary Contractor must submit its plan for risk protection for high cost cases prior to the beginning of contract negotiations. The Department will determine the acceptability of the reinsurance or alternate risk protection arrangement prior to the signing of an Agreement.

The Primary Contractor may not change or discontinue the risk protection arrangement without prior approval from DPW. The Primary Contractor must notify DPW 45 days prior to any change in the risk protection arrangement. The Department reserves the right to review such risk protection arrangements and require changes based on the Department's assessment of the Primary Contractor's overall financial condition.

3) Insolvency Arrangement/Secondary Liability

Each Primary Contractor must submit its plan, prior to the beginning of contract negotiations, to provide for payment to providers by a secondarily liable party after a default in payment to providers resulting from bankruptcy or insolvency. The secondarily liable party must insure payment to providers for all services performed by the BH-MCO's providers through the last day for which DPW paid a capitation premium to the BH-MCO. The insolvency arrangement must be at a minimum, the equivalent of two months' worth of unpaid claims, when determinable, or two months of expected capitation revenue, in the absence of claims history. The requirement may be met by submitting one or more of the following arrangements:

- i) insolvency insurance;
- ii) an irrevocable, unconditional and automatically renewable letter of credit

- for the benefit of DPW, which is in place for the entire term of the Agreement;
- iii) a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Primary Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or
 - iv) other arrangements, satisfactory to the Department, that are sufficient to ensure payment to providers in the event of a default in payment resulting from bankruptcy or insolvency.

The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency.

DPW must approve all such arrangements prior to the signing of an Agreement. Such approval will include approval of the financial strength of the secondarily liable parties and approval of all legal forms for secondary liability.

The Primary Contractor is required to submit its insolvency arrangement to DPW annually. Any proposed changes must be submitted to DPW for approval at least 45 days prior to any change becoming effective.

- 4) Equity Requirements - This section applies only if the Primary Contractor is a county operated BH-MCO.
 - a. The Primary Contractor is required to meet and maintain minimum equity requirements for its Agreement throughout the life of the Agreement. The purpose of the standard is to assure payment of the BH-MCO's obligations to providers and to assure performance by the BH-MCO of its obligations under the Agreement.

Each Primary Contractor must maintain minimum equity equal to the 5% of annual HealthChoices capitation revenue. Annual HealthChoices capitation revenue refers to amounts paid by DPW to the Primary Contractor.

No later than forty-five days prior to the effective date of this Agreement, the Primary Contractor must provide documentation that equity equal to or greater than 50% of the Department's capitation obligation for the fourth quarter of 2001 is being met, or will be met, by the effective date of the Agreement.

The requirement may be phased in during the first four calendar quarters of the Agreement. The following phase-in calculation, which will be reviewed for compliance every quarter during the first Agreement period,

will be computed as follows:

End of 1st Quarter:

4.4% of annual capitation revenue [(derived by averaging the first 3 months and then annualizing) multiplied by 4.4%].

End of 2nd Quarter:

4.6% of annual capitation revenue [(derived by averaging the first 6 months and then annualizing) multiplied by 4.6%].

End of 3rd Quarter:

4.8% of annual capitation revenue [(derived by averaging the first 9 months and then annualizing) multiplied by 4.8%].

End of 4th Quarter:

5.0% of annual capitation revenue [(derived by averaging the first 12 months and then annualizing) multiplied by 5.0%].

Primary Contractors must provide DPW with a Statement of Revenues and Expenses, Balance Sheet, and a Statement of Cash Flows, not later than 45 days after the end of each month (See Appendix P, Reports #13, 14, and 15). Statements must be consistent with Generally Accepted Accounting Principles (GAAP). These financial statements must include only information applicable to this Agreement. Each quarter, the balance sheet that provides information as of the last day of a calendar quarter must be accompanied by a certification, by an independent actuary, of the liabilities shown on the Balance Sheet (See Appendix P, Report #13).

Equity requirements will be determined at the end of each quarter, based on the contract-specific Balance Sheet. Assets held to meet the minimum equity requirements must be in a form accepted by the ID as an "allowable asset." Assets held to meet the equity requirements must be maintained in a Restricted Reserve Account. This account must be established by applicable municipal ordinance and will maintain funds for the exclusive use as a reserve under the Agreement. Withdrawals from this account will be made only with expressed written approval by DPW. Copies of the bank statements verifying deposits must be mailed, directly from the banking institution, to the Department monthly. The amounts held in the Restricted Reserve Account as of the last day of the calendar quarter will be compared to the minimum equity requirement amounts in order to determine compliance with this standard.

The Primary Contractor is required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If not in compliance with the requirements

of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements of its Agreement.

If the Primary Contractor fails to comply with the requirements of this section, the Department may take any or all of the following actions:

- discuss fiscal situation with the Primary Contractor's management;
 - require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
 - suspend enrollment of some or all recipients into the BH-MCO;
 - terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.
- b. The Primary Contractor shall account for its HealthChoices transactions in an Enterprise Fund.
- c. Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et seq.) to pay for HealthChoices Program costs.
- 5) This section applies only if the Primary Contractor is a county and if all the following conditions apply:
- the county subcontracts with a private sector BH-MCO; and
 - the cost of the BH-MCO subcontract is at least 80% of the revenue the county receives from DPW under this Agreement; and
 - the subcontract between the county and the BH-MCO subcontractor provides that the BH-MCO subcontractor is substantially at risk to provide services without financial recourse to the county.

The requirements of Sections 2), 3), and 4)a. above also apply to the private-sector BH-MCO subcontractor if the subcontract between the county and the subcontracting private-sector BH-MCO requires that the private-sector BH-MCO subcontractor meet and maintain the risk protection, equity and insolvency arrangement requirements stated in Sections 2), 3), and 4)a. The Primary Contractor shall account for its HealthChoices transactions in a Special Revenue

Fund.

- 6) The Primary Contractor must maintain revenues paid by the Department under this Agreement in a contract-specific bank account or accounts. These accounts will not contain funds unrelated to this Agreement. The Primary Contractor may prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.
- 7) The Primary Contractor must maintain separate fiscal accountability for Medicaid funding under the waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The Primary Contractor must maintain procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county, if the Primary Contractor has an Agreement in more than one HealthChoices county.
- 8) DPW's obligation to make payments is limited to the capitation payments provided by DPW's Agreement. If DPW is obligated as a result of litigation to pay a provider for a service rendered under this Agreement, the Primary Contractor will have an obligation to DPW in the same amount. DPW may offset an obligation it has to the Primary Contractor by this amount, or DPW may demand payment from the Primary Contractor.
- 9) Limitation of Liability

In accordance with 42 CFR 434.20, the Primary Contractor must assure that MA recipients will not be liable for the Primary Contractor or subcontracting BH-MCO's debts if the Primary Contractor or subcontracting BH-MCO becomes insolvent.

The BH-MCO must also include in all of its provider agreements a continuation of benefits clause, which states that the provider agrees that in the event of the BH-MCO's insolvency or other cessation of operations, the provider will continue to provide benefits to the BH-MCO Members through the period for which the premium has been paid, including Members in an inpatient facility.

- 10) Behavioral Health Service Cost Accruals

The Primary Contractor must have actuarial services available to provide rate and other support services needed under the Agreement. The contractor must provide DPW with an actuarial certification of liabilities quarterly, if a county-operated BH-MCO, and at least annually, if a licensed, risk-bearing entity. As part of its accounting and budgeting function, the BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The BH-MCO should reserve funds by major categories of service

(e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the BH-MCO should conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary.

11) Financial Performance

The Department will monitor the financial performance of the Primary Contractor and its major subcontractors. Monitoring will include, but not be limited to, financial viability, profit, and appropriateness of medical and administrative expenditures.

12) Reporting Penalty

If the Primary Contractor fails to provide any report, audit, or file that is specified by the Agreement by the applicable due date, or if the Primary Contractor provides any report, audit, or file specified by the Agreement that does not meet established criteria, a subsequent payment to the Primary Contractor may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date or any extension due date granted by the Department, and the day that the Department receives a report, audit, or file that meets established criteria, multiplied by the average Per-Member-Per-Month capitation rate that applies to the first month of the Agreement period. If the Primary Contractor provides a report, audit, or file on or before the due date, and if the Department notified the Primary Contractor after the 15th calendar day after the due date that the report, audit, or file does not meet established criteria, no reduction in payment will apply to the 16th day after the due date through the date that the Department notified the Primary Contractor.

B. Acceptance of Department Capitation Payments

The Primary Contractor is capitated for all in-plan services. The obligation of the Department to make payments is limited to capitation payments. The Department shall make capitation payments to the Primary Contractor on a monthly basis in the following manner:

- On the first day of each month, the Department will identify Members, and for each Member whose enrollment is effective on the first of the month, as indicated on CIS, the Department shall make a prepaid, per Member per month (PMPM) payment as payment in full for any and all services provided to the Member that constitutes covered services. Payment will be released no later than the 15th day of the month. Enrollment on the first of the month that is added to CIS after the first of the month will result in a capitation payment at a later date.

- For Members whose enrollment is effective at any time after the first day of the

month, capitation will be prorated and paid at a later date. Capitation payments for the second and subsequent months will be paid in the manner described above.

- Appendix V, the HealthChoices Behavioral Health Recipient Coverage document, provides for adjustments to the Department's obligation to make capitation payments. Appendix V is subject to revision by the Department in its sole discretion and without the need to amend the Agreement.
- The capitation payment will be equal to the amount awarded the Primary Contractor through the rating setting process. Monthly capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

The Agreement will provide for rates for SSI consumers who have Medicare Part A benefits that are distinct from rates for SSI consumers who do not have Medicare Part A benefits. If the Department's TPL file is updated to indicate Medicare Part A coverage within four (4) months prior to the current month for a consumer at an SSI without Medicare rate, the Department will adjust the payment to reflect the rating group appropriate to the consumer, provided the TPL file indicates Part A coverage as of the first day of coverage by the Primary Contractor for this consumer during the program month for which payment was made. If the Department's TPL file is updated to adjust or delete indication of Medicare Part A coverage within four (4) months of a payment to the Primary Contractor for a consumer at an SSI with Medicare or Healthy Horizons rate, the Department will adjust the payment to reflect the rating group appropriate to the consumer, provided the TPL file does not indicate Part A coverage as of the first day of coverage by the Primary Contractor for this consumer during the program month for which payment was made. The Department will provide information to the Primary Contractor on this type of payment adjustment on an electronic file. The Primary Contractor will utilize this information to adjust its payments to providers and instruct its providers to bill Medicare.

The Department will recover capitation payments made for the Members 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 recipients for up to eighteen (18) months after the service month for which payment was made. (See Appendix V, HealthChoices BH Recipient Coverage Document.)

The Primary Contractor must agree to accept capitation payments in this manner and must have written policies and procedures for receiving, reconciling and processing capitation payments.

C. Physician Incentive Arrangements

The Primary Contractor may operate a physician incentive plan only in accordance with Federal Requirements for Physician Incentive Plans.

- 1) If the primary or subcontracting BH-MCO is an HMO, the following requirements apply:

Per 42 CFR 417.479(a), no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee.

The HMO must disclose to the State the information on provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i) at the times indicated at 42 CFR 434.70(a)(3), in order to determine whether the incentive plan(s) meets the requirements of 42 CFR 417.479(d)-(g). As applicable, the HMO must provide the capitation data required under paragraph (h)(1)(vi) for the previous calendar year to the State by April 1 of each year. HMO will provide the information on its physician incentive plans listed in 42 CFR 417.479(h)(3) to any Medicaid client, upon request.

- 2) If the Primary Contractor is a Prepaid Health Plan (PHP) or enters into a subcontract with a PHP, the following HCFA requirements must be met:

The Contractor must disclose to the State the information on its provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i), at the times indicated at 42 CFR 434.70(a)(3), in order to determine whether the incentive plans meet the requirements of 42 CFR 417.479(d) - (g) when there exists compensation arrangements under the Agreement where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903(s) of the Social Security Act. Contractor will provide the information on its physician incentive plans listed in 42 CFR 417.479(h)(3) to any Medicaid client, upon request.

D. Claims Payment and Processing

- 1) Payments to Providers

The Department believes that one of the advantages of a behavioral health managed care system is that it permits Primary Contractors and BH-MCO subcontractors to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. The Department therefore intends to give Primary Contractors and BH-MCO subcontractors as much freedom as possible to negotiate mutually acceptable

payment rates. However, regardless of the specific arrangements made with providers, the Primary Contractor and BH-MCO subcontractors must agree to make timely payments to both contracted and non-contracted providers, subject to the conditions described below. The Primary Contractor and BH-MCO subcontractor must also agree to abide by special reimbursement provisions for FQHCs described below.

The contractor agrees to negotiate and pay rates to FQHCs and RHCs comparable to other providers who provide comparable services in the contractor's provider network. The BH-MCO may require that an FQHC comply with case management procedures that apply to other entities that provide similar benefits or services.

The Primary Contractor and/or BH-MCO subcontractor shall not be obligated to pay providers of authorized behavioral health services unless bills for such services are submitted within one hundred and eighty (180) days from the date of service.

The Primary Contractor and/or BH-MCO subcontractor shall follow state law on invoicing requirements on uniform claims, including the HCFA 1500 and UB92.

- 2) The Primary Contractor and/or BH-MCO subcontractor shall adjudicate 90% of all clean claims within 30 days, 100% of clean claims within 45 days, and 100% of all claims within 90 days. The Primary Contractor shall provide the Department with a monthly report that supplies summary information on claims processed. This reporting requirement applies to claims processed by the Primary Contractor, or a subcontractor, as well as capitation payments to providers or subcontractors of behavioral health services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8), and are also available in the HealthChoices Library.

E. Retroactive Eligibility Period

The Primary Contractor and BH-MCO will not be responsible for any payments owed to providers for services that were rendered prior to a Member's effective date of enrollment.

F. Financial Responsibility for Dual Eligibles

The Contractor must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the contracted BH-MCO rate for the service for network providers.

If no contracted BH-MCO rate exists or if the provider of the service is an out-of-network

provider, the Contractor must pay deductibles and coinsurance up to the applicable Medical Assistance fee schedule amount for the service.

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

In the event that payment for a service is not covered by Medicare, the BH-MCO may require prior authorization as a condition of payment for the service.

G. Risk and Contingency Funds

- 1) The Primary Contractor may use Risk and Contingency Funds for the following purposes:
 - a. To provide in-plan services and administrative functions required by this document, due to fluctuations in enrollment, revenue and utilization which have caused costs to exceed available capitation payments;
 - b. To make payment to subcontractors due to any delay(s) of thirty (30) days or more of receipt of a monthly capitation payment from the Department.
 - c. With prior written approval from the Department, to meet the Primary Contractor's insolvency arrangement plan under Part II-7 A. of this document; or
 - d. With prior written approval from the Department to meet the Primary Contractor's reinvestment plan.
- 2) Risk and Contingency Funds shall at no time exceed the equivalent of ninety (90) days worth of unpaid claims as determined by the Department. If Risk and Contingency Funds exceed the equivalent of ninety (90) days worth of unpaid claims at the end of any Agreement year, the Primary Contractor shall return the excess portion to the Department, within fifteen (15) days of written notification from the Department. If the Risk and Contingency Fund is also being used to meet the Department's insolvency protection arrangement requirements, the amount of the insolvency requirement (2 months of unpaid claims) will be included in the calculation of the 90 days worth of unpaid claims. The Risk and Contingency Fund would then need to be funded, at a minimum, of 60 days (or two months) worth of unpaid claims at all times. Funds designated in a reinvestment plan submitted to the DPW will not be included in the calculation of the 90 days' worth of unpaid claims.

- 3) The Risk and Contingency Fund shall be reported as a separate line item on the monthly financial report and audited Balance Sheet submitted for the annual Agreement audit, including a statement of cash flow.
- 4) Within fourteen (14) months from the termination of the Agreement, any Risk and Contingency Funds remaining in the Primary Contractor's HealthChoices Special Revenue or Enterprise Fund for the HealthChoices Behavioral Health Program shall be returned to the Department.
- 5) In the event that the Department enters into another agreement with the Primary Contractor for the provision of HealthChoices Behavioral Health services subsequent to a current Agreement's termination, the Department reserves the right, in its sole discretion, to allow the Primary Contractor to retain all, or a portion thereof, of Risk and Contingency Funds otherwise owed to the Department.

H. Return of Funds

The Primary Contractor must return any unexpended Reinvestment Funds to the Department within six (6) months from the time period approved for such expenditure unless such date is otherwise extended by the Department.

In the event that the Agreement with the Department ends and is not renewed, all funds, except for those in DPW approved reinvestment plans, or reinvestment funds in a plan submitted to DPW but which DPW has not taken a positive or negative action, remaining in the Primary Contractor's Special Revenue Fund or Enterprise Fund, inclusive of Risk and Contingency Funds, not expended for HealthChoices Behavioral Health transactions, must be returned to the Department within 14 months from the expiration of the Agreement.

I. In-Network Services

The Primary Contractor will be responsible for making timely payment for medically necessary, covered services.

1) In-Network Providers

The BH-MCO will be responsible for making timely payment for medically necessary, covered services rendered by in-network providers when:

- a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or
- b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or
- c. Services were rendered under the terms of the BH-MCOs contract with the provider; or

- d. Services were prior authorized.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for emergency room evaluations for voluntary or involuntary commitments pursuant to the Mental Health Procedures Act of 1976 which will be the responsibility of the BH-MCO.

2) Out-of-Network Providers

The BH-MCO will be responsible for making timely payments to out-of-network providers for medically necessary, covered services when:

- a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or
- b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or
- c. Services were prior authorized by the BH-MCO; or
- d. Medically necessary services were rendered during an emergency placement by the child welfare agency.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO.

3) Liability During an Active Provider Complaint

The BH-MCO will not be liable to pay claims to providers if the validity of the claim is being challenged by the BH-MCO through a complaint process or appeal, unless the BH-MCO is obligated to pay the claim or a portion of the claim through its contract with the provider.

J. Third Party Liability (TPL)

The Primary Contractor must comply with the third party liability procedures defined by Section 1902(a)(25) of the Social Security Act and implemented by the Department. Under this Agreement, the third party liability responsibilities of the Department will be allocated between the parties as indicated below.

1) Cost Avoidance Activities

- a. The Primary Contractor has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. 1396a(a)(25) plans, and

workers compensation. The Primary Contractor must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are applicable or the probable liability of another type of health-related resource is established. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the COB flag, Medicare fields, and the Other Insurance Paid (OIP) field shall indicate that TPL has been pursued and the amount which has been cost-avoided. The Primary Contractor shall not be held responsible for any TPL errors in the Department's Eligibility Verification System (EVS) or the Department's TPL file.

- b. The Primary Contractor agrees to pay, and to require that its subcontractors pay, all clean claims for EPSDT services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the Primary Contractor is notified by the Department of such support orders or to the extent the Primary Contractor becomes aware of such orders, and then seek reimbursement from liable third parties. The Primary Contractor recognizes that cost avoidance of these claims is prohibited.
- c. The Primary Contractor may not deny or delay approval of otherwise covered treatment or services based upon third party liability considerations. The Primary Contractor may neither unreasonably delay payment nor deny payment of claims unless the probable existence of third party health-related insurance coverage is established at the time the claim is filed.

2) Post-Payment Recoveries

- a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) other resources. Health-related insurance coverage is ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The term "other resources" means all other resources and includes, but is not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.
- b. The Department's TPL Section retains the sole and exclusive right to investigate, pursue, collect, and retain all "other resources" as defined in paragraph 2)a. above. Any correspondence or inquiry forwarded to the Primary Contractor (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 consumer and the services which were

provided, must be immediately forwarded to the Department's TPL Section. The Primary Contractor may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident, the services are otherwise covered. Those funds recovered by the Commonwealth under the scope of these "other resources" shall be retained by the Commonwealth.

- c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the Primary Contractor's untimely submission of notice of legal involvement where the Primary Contractor has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Primary Contractor. 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.
- d. The Primary Contractor has the sole and exclusive 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 Department's TPL Section may pursue, collect, and retain recoveries of all health-related insurance cases which are outstanding after the earlier of nine (9) months from the date of service or six (6) months after the date of payment. However, in those cases subject to this paragraph where payment is being pursued by the Primary Contractor but, for whatever reason, has not been collected by the earlier of nine (9) months from the date of service or six (6) months after the date of payment, the Primary Contractor shall notify the Department if action to recover has been initiated by the Primary Contractor. In such cases, the Primary Contractor shall retain exclusive responsibility for the cases while they are being actively pursued.
- e. 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 billing that specific claim is directly related to untimely submission of encounter data, 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 Primary Contractor.
- f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this document 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 liability against the Primary Contractor.

- g. As part of its authority under paragraph 2)d. above, the Primary Contractor is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The Primary Contractor is encouraged to develop and implement cost-effective procedures to identify and pursue cases which are susceptible to collection through either legal action or traditional subrogation and collection procedures.

3) Health Insurance Premium Payment (HIPP) Program

The HIPP Program pays for employment-related health insurance for MA consumers when it is determined to be cost effective. The cost effectiveness determination involves the review of group health insurance benefits offered by employers to their employees to determine if the anticipated expenditures in MA payments are likely to be greater than the cost of paying the premiums under a group plan for those services.

The Department shall not purchase Medigap policies for equally eligible MA consumers in the HealthChoices project area.

4) Requests for Additional Data

The Primary Contractor 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. The Primary Contractor shall use its best efforts to provide this information within fifteen (15) calendar days of the Department's request. There are certain urgent requests involving cases for minors that require information within 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 shall be maintained as required by federal and state regulations.

5) Accessibility to TPL Data

The Department shall provide the Primary Contractor with accessibility to data maintained on the TPL file.

6) Third Party Resource Identification

Third party resources identified by the BH-MCO, which do not appear on the Department's TPL database, must be supplied to the Department's TPL Section by the primary contractor or subcontractor BH-MCO on a monthly basis. The method

of reporting shall be electronic submission or hard copy document, whichever is deemed most convenient and efficient by the primary contractor or subcontractor BH-MCO for its individual use. For electronic submissions, the primary contractor or subcontractor BH-MCO must follow the required report format, data elements, and tape specifications supplied by the Department. For hard copy submissions, the primary contractor or subcontractor BH-MCO must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department's TPL Section will use these submissions for subsequent updates to the system.

7) Damage Liability

Liability for damages is identified in this section due to the large dollar value of many claims which are potentially recoverable by the Department's TPL Section.

8) Estate Recovery

Section 1412 of the Public Welfare Code, 62 P.S. 1412 requires the Department to recover MA costs paid on behalf of certain deceased individuals. Individuals age fifty-five (55) and older who were receiving MA benefits for any of the following services are affected:

- a. Public or private nursing facility services;
- b. Residential care at home or in a community setting; or
- c. Any hospital care and prescription drug services provided while receiving nursing facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's TPL Program is solely responsible for administering the Estate Recovery Program.

K. Performance Management Information System and Reporting

1) General

The requirement that the Primary Contractor and subcontracting BH-MCO provide the requested data is a result of the terms and conditions established by HCFA. HCFA specified that the state define a minimum data set and require all Primary Contractors and subcontracting BH-MCOs to submit the data.

To measure the BH-MCO's actual accomplishments in the areas of access to care, behavioral health outcomes, quality of life, and Member satisfaction, the

Primary Contractor and subcontracting BH-MCO must agree to provide the Department with uniform service utilization, quality management, and Member satisfaction/complaint/grievance data on a regular basis. The Primary Contractor and subcontracting BH-MCO also must agree to cooperate with the Department in carrying out data validation steps. The Department intends to use this information as part of a collaborative effort with the BH-MCOs to effect continuous quality improvement.

This data will include components specified by the Department and also problem areas targeted by the continuous quality improvement program, both of which may change from time to time.

The Primary Contractor and the BH-MCO will manage the program in compliance with the Department's standards and requirements and will provide data reports to support this management.

The Department's detailed report formats and variable definitions for the Primary Contractor and subcontracting BH-MCO to use in providing operational data are in the HealthChoices Behavioral Health Performance Outcome Management System Reporting Manual, Aggregate Encounter and Complaint and Grievance and Reinvestment Reporting Manuals, HealthChoices Requirements and Specifications Manual for Encounter Data/Subcapitation Financial Data, Transition Monitoring and Quarterly Monitoring Reports Manual, MCO Provider File Manual, HCFA Reports Manual and Financial Reporting Guidelines available in the HealthChoices Library.

It is the Department's right to request medical records directly from BH-MCO's and BH services providers for issues related to quality of care, behavioral health outcome measures, Third Party Liability (TPL), and fraud and abuse.

2) Management Information System

The Department requires an automated management information system (MIS). There are numerous components required for the complete system. They are service authorization, Member complaint and grievance, provider complaint, provider profiling, claims processing including TPL identification, Membership enrollment, financial reporting, utilization management, encounter data, performance outcomes, quality assurance, and suspected/substantiated fraud and abuse. Of these components, service authorization, provider profiling, claims processing (including TPL) encounter data and membership enrollment must be integrated.

The BH-MCO's MIS must be compatible with the Department's Pennsylvania Open Systems Network (POSNet).

The Primary Contractor must comply with the policy and procedures governing

the operation of the Department's Pennsylvania Open Systems Network (POSNet), as defined in the document POSNet Interface Specifications contained in the HealthChoices Library.

The Primary Contractor must comply with all changes made to the POSNet Interface Specifications by DPW, or modifications made to the specifications by the Office of Medical Assistance or the Office of Mental Health and Substance Abuse Services.

The BH-MCO is required to maintain an automated provider directory. Upon request the BH-MCO is required to provide this directory to the Department via POSNet or via diskette.

The MIS must include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

3) Encounter and Subcapitation Data

The Department requires the BH-MCO to submit a separate record, or "pseudo claim," each time a Member has an encounter with a provider. This includes encounters with providers which are reimbursed on a fee-for-service, retainer, subcapitation and case rate basis. An encounter is a service provided to a Member. This would include, but not be limited to, a professional contact between a Member and a provider and will result in more than one encounter if more than one service is rendered. For services provided by BH-MCO contractors and subcontractors, it is the responsibility of the BH-MCO to take appropriate action to provide the Department with accurate and complete encounter data. The Department's point of contact for encounter data will be the Primary Contractor not its contractors and/or subcontractors.

The Department requires the BH-MCO to submit a separate subcapitation record for each advance payment made to a contractor responsible for all or part of a Member's behavioral health care. If the payment is a capitation payment, a separate record is required to report the amount paid on behalf of each Member. It is the responsibility of the BH-MCO to take appropriate action to provide the Department with accurate and complete subcapitation data for payments made by BH-MCO to its contractors and subcontractors; the Department's point of contact for subcapitation data will be the Primary Contractor not its contractors and subcontractors.

The Department will validate the accuracy of data on the encounter and subcapitation data files. Validation criteria is included for each data element in the Requirements and Specifications Manual for Encounter Data/Subcapitation Financial Data and in the Aggregate Encounter and Complaint and Grievance Reporting Manuals, both of which are found in the HealthChoices Library.

- a. Person-Level Record. The person level record must include, at a minimum, the data elements listed in the Requirements and Specifications Manual for Encounter Data/Subcapitation Financial Data.
- b. Aggregate Data. The aggregate data submittal must include, at a minimum, the data elements/reports listed in the Aggregate Encounter and Complaint and Grievance Reporting Manuals.
- c. Data Format. The Primary Contractor and subcontracting BH-MCO must agree to submit Encounter and Subcapitation data electronically over the POSNet using the FTP protocol. Data file content must conform to the requirements specified in the Requirements and Specifications Manual for Encounter Data/Subcapitation Financial Data and the Aggregate Encounter and Complaint and Grievance Reporting Manuals.
- d. Timing of Data Submittal.

An encounter must be submitted and found acceptable on first-level edits by the Department on or before the last calendar day of the second month after the calendar quarter in which the Primary Contractor paid/adjudicated the encounter. The encounter records must be submitted and found acceptable on second-level edits by thirty (30) days after the Primary Contractor receives notification from the Department of the records which must be adjusted to meet second-level edit criteria. References to “accepted by the Department” refer to encounter records sent to DPW by the Primary Contractor that have passed all Department edits; records that fail any Department edits are returned to the Primary Contractor and must be corrected or adjusted, resubmitted to the Department, and pass all edits before they are accepted by the Department.

One “initial” file and one “correction” file may be submitted each week.

Acceptable subcapitation data must be submitted and found acceptable to the Department within sixty (60) days after the end of the calendar quarter of the subcapitation payment date.

- e. Member Medical Information

When requested, the Primary Contractor must provide a Member's medical records within 15 days of the Department's request.

- f. Liquidated Damages.

The Primary Contractor is required to provide complete, accurate, and timely encounter data to the Department and to maintain complete

medical records. These requirements are explained in a. through e. above. Failure to comply may result in liquidated damages. The Department may withhold capitation premiums as reimbursement for liquidated damages assessed. Liquidated damages will be calculated quarterly.

Assessment of liquidated damages is based on the identification of Penalty Occurrences. Penalty Occurrences are assessed as follows:

- i) This section assesses penalties for encounters and subcapitation payments sent late but within 365 days of the date of service;

encounters accepted late by the Department (this and subsequent references to "accepted by the Department" refer to encounter records sent to DPW by the BH-MCO that have passed all Department edits; records that fail any Department edits are returned to the BH-MCO, and must be corrected, resubmitted to the Department, and pass all edits before they are accepted by the Department);

no Penalty Occurrence - For encounters, difference between the date the correct record is accepted by the Department and the BH-MCO Adjudication Date is 175 days or less. For subcapitation records, the difference between the date the correct record is accepted by the Department and the end of the month in which BH-MCO payment occurs is 122 days or less;

one Penalty Occurrence - For encounters, difference between the date the correct record is accepted by the Department and the BH-MCO Adjudication Date is between 176 and 205 days. For subcapitation records, the difference between the date the correct record is accepted by the Department and the end of the month in which BH-MCO payment occurs is between 123 and 152 days;

two Penalty Occurrence - For encounters, difference between the date the correct record is accepted by the Department and the BH-MCO Adjudication Date is between 206 and 235 days. For subcapitation records, the difference between the date the correct record is accepted by the Department and the end of the month in which BH-MCO payment occurs is between 153 and 182 days;

there will be an additional Penalty Occurrence for each additional 30 days between the date the record is accepted by the Department and the BH-MCO Adjudication Date;

- ii) this section assesses penalties for encounters received by DPW

more than a year after the date of service. Those late encounters could be due to the provider not sending the encounter to the BH-MCO, the BH-MCO holding the encounter too long before sending it to DPW, or DPW's learning that the provider did not send the encounter to the BH-MCO;

the Department may assess one Penalty Occurrence for encounters not received by DPW within 365 days after the date of service, regardless of whether the encounter data was sent to the BH-MCO;

an additional one Penalty Occurrence may be assessed for each 90 day delay in DPW receipt beyond 365 days;

these Penalty Occurrences are in addition to any Penalty Occurrences that may accrue because of conditions in i) above;

- iii) this section assesses penalties for late submission of a recipient's medical records;

when the Department requests from the Primary Contractor medical information from the Member's medical records, and this information is not received within 15 days of the request, one Penalty Occurrence may be imposed; when initially imposed, the penalty will be applicable to the quarter of the 16th day after the request was made;

for each additional 30 days the required medical information has not been satisfactorily provided, one additional Penalty Occurrence may be imposed;

additional Penalty Occurrences will apply to the quarter when the 30 day period expires;

- iv) this section describes the quarterly calculation of liquidated damages for encounter records;

to determine the liquidated damages for a quarter, divide the number of Penalty Occurrences for the quarter by the number of encounters accepted by DPW for the quarter. The percentage in excess of 3% is multiplied by the net capitation premiums for the quarter to determine the financial penalty. For example:

- . Cumulative Penalty Occurrences for 1st quarter 2002 is 10,000.
- . Total encounters accepted for 1st quarter 2002 is

150,000.

- . Net capitation premiums for 1st quarter 2002 is \$10,000,000.
- . 10,000 Penalty Occurrences divided by 150,000 total encounters is 6.6666%.
- . The financial penalty for the quarter is 3.6666% of \$10,000,000 -- \$366,666.67.

- v) this section describes the quarterly calculation of liquidated damages for subcapitation records;

to determine the liquidated damages for a quarter, divide the number of Penalty Occurrences for the quarter by the number of subcapitation records accepted by the Department for the quarter. The percentage in excess of 3% is multiplied by the net capitation premiums for the quarter to determine the financial penalty. For example:

- . Cumulative Penalty Occurrences for 1st quarter 2002 is 10,000.
- . Total subcapitation records accepted for 1st quarter 2002 is 150,000.
- . Net capitation premiums for 1st quarter 2002 is \$10,000,000.
- . 10,000 Penalty Occurrences divided by 150,000 total subcapitation records is 6.6666%.
- . The financial penalty for the 1st quarter 2002 is 3.6666% of 10,000,000 -- \$366,666.67.

- g. Data Validation

The BH-MCO must agree to assist the Department in its validation of utilization data by making available medical records and its claims data. The validation may be completed by Department staff and independent, external review organizations.

- L. Audits

All costs incurred under the Agreement are subject to audit by the Department of Public Welfare or its designee for final approval and acceptability, in accordance with industry standards, applicable accounting principles, and Federal and State regulations and policy. Additional information on auditing is contained in Appendix W and the HealthChoices

Financial Reporting Requirements, (Appendix P), also available in the HealthChoices Library.

M. Claims Processing and Management Information System (MIS)

The BH-MCO must have a comprehensive automated management information system (MIS) that is capable of meeting the requirements listed below and throughout this document. The BH-MCO MIS must comply with the requirements listed in the latest version of the MIS and System Performance Review Standards (SPR). As a reference to assist the BH-MCO in its internal systems review, a copy is available in the HealthChoices Library. The Department will provide data support for the Primary Contractor and subcontractor BH-MCO as listed in Appendix O and described in the "Managed Care Data Support Overview for Behavioral Health" which can be referenced in the HealthChoices Library.

- . The Membership management system must have the capability to receive, update and maintain the BH-MCO's Membership files consistent with information provided by the Department.
- . The claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this document. Claims history must be maintained with sufficient detail to meet all Department reporting and encounter requirements.
- . The provider file must have the capability to store information on each provider sufficient to meet the Department's reporting requirements.
- . The BH-MCO must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.
- . The BH-MCO must have the capability to electronically transfer data files with the Department.
- . The BH-MCO must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification (AS) Rule for the eight electronic transactions and for the code sets used in these transactions or there must be adequate documentation to demonstrate that the system will be compliant with the standards by October 16, 2002.

The BH-MCO's information system shall be subject to review and approval at any time.

N. Reference Information

The Department will make files available to Primary Contractors on a routine basis that will allow them to effectively meet their obligation to provide services and record information consistent with Agreement requirements. The Department expects to

provide daily and monthly eligibility files, TPL monthly files, monthly payment reconciliation and summary payment files, MCO Provider Error File, ARM 568 File, MA Provider File, Procedure Code, Diagnosis Code Files and quarterly BDAP CIS files.

For more information, see Appendix O.

O. Federalizing General Assistance (GA) Data Reporting

It is an important objective of the Department to claim the maximum amount of federal funding for the MA Program that is permitted. The Primary Contractor will be required to submit a monthly file to the Department to support this objective. Failure to comply with this report requirement will result in a penalty equal to three (3) times the amount that applies to other reports. Please refer to Appendix P (FRR- Report #16) for reporting specifications.

The Department is currently developing a claims data system which, when operational, will effectively collect the necessary data for federalizing GA. However, the Primary Contractor will be responsible for submitting these monthly reports until notification is received by the Department that the required data is no longer necessary.

P. Disproportionate Share (DSH)/Graduate Medical Education (GME)

The Department will make direct payments of DSH/GME to hospitals. DSH and GME amounts will not be included in Fee-for-Service cost equivalent projections or in capitation payments paid by the Department to the Primary Contractor.