Community HealthChoices | pa health & wellness™

2025 Provider Manual

Provider services: 1-844-626-6813
TDD/TTY 711

PAHealthWellness.com

WELCOME

Welcome to PA Health & Wellness! Thank you for being part of our network of healthcare Providers. We look forward to working with you to improve the health of our Pennsylvania communities, one person at a time.

About Us

PA Health & Wellness was established to deliver quality healthcare in the state of Pennsylvania through local, regional, and community-based resources. PA Health & Wellness is a Managed Care Organization and subsidiary of Centene Corporation (Centene). PA Health & Wellness exists to improve the health of its Participants through focused, compassionate, and coordinated care. Our approach is based on the core belief that quality healthcare is best delivered locally.

PA Health & Wellness will serve Participants in the Community HealthChoices program. Community HealthChoices is a new program designed to coordinate physical healthcare and long-term services and supports (LTSS) for older persons, persons with disabilities, and Pennsylvanians who are dually eligible for Medicare and Medicaid (dual eligible).

About this Manual

The Provider Manual contains comprehensive information about PA Health & Wellness operations, benefits, policies, and procedures. The most up-to-date version can be viewed from the “For Providers” section of our website PAHealthWellness.com. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

Billing guidelines and information can be found in the PA Health & Wellness Provider Billing Manual, located in the “For Providers” section of our website PAHealthWellness.com.

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling PA Health & Wellness, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN)
- Participant's PA Health & Wellness ID number or Medicaid ID number

Department	Telephone Number	Fax Number
Provider Services	1-844-626-6813 TTY: 711	1-844-706-7719
Participant Services	1-844-626-6813 TTY: 711	1-844-706-7719
Prior Authorization Request	1-844-626-6813 TTY: 711	1-844-360-1034
Concurrent Review	1-844-626-6813 TTY: 711	1-844-883-4140
Self-Referral	1-844-626-6813 TTY: 711	
Care Management	1-844-626-6813 TTY: 711	1-844-360-9981
24 Hour Nurse Advice Line (24/7 Availability)	1-844-626-6813 TTY: 711	
DHS FFS Provider Service Center	1-800-537-8862	
DHS FFS Recipient Service Center	1-800-537-8862	
HealthChoices MCO Plan Enrollment	1-800-440-3989	

Apply for Medical Assistance	1-866-550-4355	
Adult Protective Services Abuse Hotline – 24 hours a day	1-800-490-8505	
MA Provider Compliance Hotline	1-866-379-8477	
Provider Relations	PHWProviderRelations@PAHealthWellness.com	
Paper Claims Submission	**Claim Reconsiderations**	**Pre-Service Medical Necessity Appeal**
PA Health & Wellness Attn: Claims P.O. Box 5070 Farmington, MO 63640	PA Health & Wellness Attn: Reconsideration P.O. Box 5070 Farmington, MO 63640 Fax: 1-833-641-0902	PA Health & Wellness Attn: Medical Necessity Appeals 1700 Bent Creek Blvd Mechanicsburg, PA 17050
Electronic Claims		
PA Health & Wellness c/o Centene EDI payor ID: 68069 Contact by Phone at 1-800-225-2573, ext. 6075525 or by e-mail: EDIBA@centene.com		

POPULATIONS SERVED

Community HealthChoices Participants are eligible if they meet the following criteria if they are 21 years of age or older and:

- Are dually eligible for Medicare and Medicaid; OR
- Qualify for Medicaid long-term services and supports (LTSS) because need the level of care provided by a nursing facility.

Participants are not eligible for Community HealthChoices if they are a (n):

- Act 150 program Participant;

- Person with intellectual or developmental disabilities (ID/DD) who is eligible for services through DHS' Office of Developmental Programs.
- Resident in a state-operated nursing facility, including the state veterans' homes.

VERIFYING ELIGIBILITY

Community HealthChoices Providers should verify Participant eligibility before every service is rendered, using one of the following methods:

1. **Log on to our Secure Provider Web Portal** at PAHealthWellness.com. Using our secure Provider Portal, you can check Participant eligibility. You can search by date of service and either of the following: Participant name and date of birth, or Participant Medicaid ID and date of birth.
2. **Call our automated participant eligibility IVR system.** Call 1-844-626-6813 from any touch-tone phone and follow the appropriate menu options to reach our automated Participant eligibility-verification system 24 hours a day. The automated system will prompt you to enter the Participant Medicaid ID and the month of service to check eligibility.
3. **Call PA Health & Wellness Provider Services.** If you cannot confirm a Participant's eligibility using the methods above, call our toll-free number at 1-844-626-6813. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the Participant name, Participant Medicaid ID, and Participant date of birth to check eligibility.

Through PA Health & Wellness' Secure Provider Portal, PCPs are able to access a list of eligible Participants who have selected their services or were assigned to them. The Patient List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information, including indicators for patients whose claims data show a gap in care, such as an adult BMI assessment. To view this list, log on to PAHealthWellness.com.

TIP Eligibility changes can occur throughout the month and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify Participant eligibility on the date of service.

All new PA Health & Wellness Participants receive a PA Health & Wellness Participant ID card. Participants will keep their state issued ID card to receive services not covered by the plan. A new card is issued only when the information on the card changes, if a Participant loses a card, or if a Participant requests an additional card.

TIP Possession of a Participant ID card is not a guarantee of eligibility. Use one of the above methods to verify Participant eligibility on the date of service.

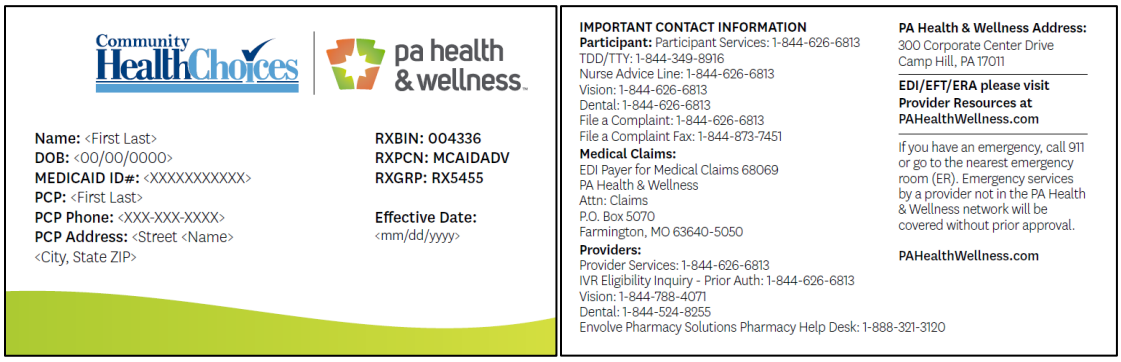
Participant Identification Card

Whenever possible, Participants should present both their PA Health & Wellness Participant ID card and a photo ID each time services are rendered by a Provider. If you are not familiar with the person seeking care as a Participant of our Health Plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services at 1-844-626-6813 immediately.

Participants must also keep their state-issued Medicaid ID card in order to receive benefits that are not covered by PA Health & Wellness.

Sample (front & back):



Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. The website allows 24/7 immediate access to current Provider and Participant information.

Please contact your Provider Relations Representative or our Provider Services department at 1-844-626-6813 with any questions or concerns regarding the website.

PA Health & Wellness website is located at PAHealthWellness.com. Providers can find the following information on the website:

- Prior Authorization List
- Applicable Forms
- PA Health & Wellness Plan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Provider Network Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

SECURE WEBSITE

The PA Health & Wellness Secure Provider Web Portal allows Providers to check Participant eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with PA Health & Wellness staff. All Providers and designated office staff have the opportunity to register for the secure Provider website in just 4 easy steps. Upon registration, tools are available that make obtaining and sharing information easy! It's simple and secure!

Go to Provider.PAHealthWellness.com to create an account. Please contact a Provider Relations Representative for a tutorial on the Secure Provider Web Portal.

Functionality

Through the Secure Provider Web Portal, you can:

- Check Participant eligibility
- View Participant health records
- View the PCP panel (patient list)
- View and submit claims and adjustments
- Verify claim status
- Verify proper coding guidelines
- View payment history
- View and submit authorizations
- Check authorization requirements
- Verify authorization status
- View Participant gaps in care
- Contact us securely and confidentially
- Add/Remove account users
- Determine payment/check clear dates
- Add/Remove TINs from a user account
- View PCP Quality Incentive Report
- View & print Explanation of Payment (EoP)

Secure Portal Disclaimer

Providers agree that all health information, **including that related to** patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care **and other related purposes as permitted by the HIPAA Privacy Rule.**

GUIDELINES FOR PROVIDERS

Medical Home Model

PA Health & Wellness is committed to supporting its network Providers in achieving recognition as Medical Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated Care Management processes.

PA Health & Wellness will support Providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®- PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The purpose of the Medical Home program is to promote and facilitate a Medical Home model of care that will provide better healthcare quality, improve self-management by Participants of their own care and reduce avoidable costs over time. PA Health & Wellness will actively partner with Providers, community organizations, and groups representing our Participants to increase the numbers of Providers who are recognized as Medical Homes (or committed to becoming recognized).

PA Health & Wellness has dedicated resources to ensure its Providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted Providers

- Education on the process of becoming certified
- Resources, tools, and best practices

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Participant panel roster (including Participant detail information)

For more information on the Medical Home model or to how to become a Medical Home, contact your Provider Relations Representative.

Referrals

Obtaining referrals from the PCP are not required by PA Health & Wellness as a condition of payment for services. PA Health & Wellness prefers that the PCP coordinates healthcare services. PCPs are encouraged to refer a Participant to another Provider when medically necessary care is needed that is beyond the scope of what the PCP can provide.

The PCP must obtain prior authorization from PA Health & Wellness for referrals to certain Specialty Providers as noted on the prior authorization list. All out-of-network services require Prior Authorization as further described in this manual, except for family planning, emergency room, and table-top x-ray services. Providers are also required to promptly notify PA Health & Wellness when prenatal care is rendered.

PA Health & Wellness encourages Specialists to communicate to the PCP the need for a referral to another Specialist. This allows the PCP to better coordinate care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the Provider or a member of the Providers' family has a financial relationship.

Participants with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Participant, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the Participant's disabling condition, chronic illness, or special healthcare needs in accordance with the PCP responsibilities included in this manual. To initiate a PCP change to a Specialist, Participants should contact PA Health & Wellness Participant Services at our toll-free number. The Health Plan will verify the change with the current PCP and the intended Specialist to be assigned as the PCP and coordinated the PCP change.

PA Health & Wellness allows an Out-of-Network I/T/U (Indian Tribe, Tribal Organization, or Urban Indian Organization) HCP (Heath Care Provider) to refer a Participant who is an Indian to a CHC-MCO Network Provider as defined in 42 CFR § 438.14(a).

Self-Referral

Participants do not need a prior-authorization or referral for the following types of services when they are rendered by a PA Health & Wellness participating Provider:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine mammograms
- Family planning services
- Routine dental services
- Routine eye exams
- First visit to a chiropractor
- Emergency services
- DME purchases costing less than $500 that are covered by the MA program with a prescription

Non-Covered Services

Non-Covered services are services that are not covered by PA Health & Wellness. Participants may be able to obtain Non-Covered Services under the Medicaid State Plan. PA Health & Wellness is responsible for informing Participants about how to access Non-Covered Services, providing all required referrals, and assisting in the scheduling of these service. These services will be paid for by the State on an FFS basis. Please visit our website at PAHealthWellness.com or call Provider Services at 1-844-626-6813 for a complete listing of these services.

Appointment Availability and Access Standards

PA Health & Wellness follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. PA Health & Wellness monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization. For the complete Community HealthChoices Provider Network Composition/Service Access standards, please see Appendix I of this Provider Manual.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers, OB-GYN, Certified Nurse Midwifes	Timeframe
Emergency Medical Condition	**Immediately seen or referred to an emergency facility**
Urgent Medical Condition	Within twenty-four **(24) hours** of presentation or request
Non-Urgent Sick Visits	Within seventy-two **(72) hours** of request, as clinically indicated.
Routine Appointments	Within ten **(10) business days**.
Health Assessment/General Physical Examinations and First Examinations	Within three **(3) weeks** of enrollment or request
Pregnant Women	**First Trimester**- within ten **(10) business days** of the participant being identified as being pregnant **Second Trimester**- within five **(5) business days** of the participant being identified as being pregnant **Third Trimester**- within four **(4) business days** of the participant being identified as being pregnant **High-Risk pregnancies**- within twenty-four **(24) hours** of identification of being high risk

Specialists	Timeframe
Emergency Medical Condition	**Immediate** upon referral
Urgent Medical Condition	Within twenty-four **(24) hours** of referral
Routine Care	Within thirty **(30) calendar days** for all specialty Provider types

Primary Care Provider, Maternity, and Specialist	Office Wait Times
Walk-in	Within two **(2) hours** or schedule an appointment within the standards of appointment availability
Previously scheduled appointment	Within one **(1) hour** of appointment
Life-threatening emergency	**Immediate**

PA Health & Wellness offers a comprehensive network of PCPs, Specialty Physicians, Hospitals, Diagnostic, and Ancillary Service Providers to ensure every Participant has access to covered services. Below are the travel distance and access standards that PA Health & Wellness utilizes to monitor network adequacy:

Specialty	Access Requirement
PCP	At least two (2) appropriate PCPs who are accepting new patients, whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. Participants may, at their discretion, select PCPs located further from their homes.
Specialists General Surgery	choice of at least two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

Specialty	Access Requirement
Optometry Rehabilitation Neurological Surgery Urology Dermatology Oral Surgery Common Laboratory and Diagnostic Service Obstetrical and Gynecological Service Orthopedic Surgery Allergy and Immunology Otolaryngology Neurology Cardiology Gastroenterology Podiatry Pharmacy	
Specialists Endocrinologist Rheumatology Nephrology Hematology/Oncology Speech Therapy	(1) Provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the CHC Zone.
Hospitals	At least one (1) hospital within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) and a second (2nd) choice within the CHC zone. This travel time is measured via public transportation, where available.

Specialty	Access Requirement
Anesthesiology and Anesthesia for Dental Care	(2) Anesthesiologists available for each location that performs medical procedures that require aesthesia. For Participants needing anesthesia for dental care, the CHC-MCO must ensure a choice of at least two (2) Dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia.
Rehabilitation Facilities	At least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this CHC zone.
Certified Nurse Midwives (CNMs) Certified Registered Nurse Practitioners (CRNPs) and other Providers	PA Health & Wellness will contract in good faith with a sufficient number of CNMs, CRNPs and other Providers.
FQHCs/RHCs	A sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access. FQHC and RHC sites may be designated as Primary Care sites.
Opioid Use Disorder Centers of Excellence (OUD-COE)	A sufficient number of Physical Health Opioid Use Disorder Centers of Excellence (OUD-COE).
FTE -As defined in the requirement.	Personal Assistance Services (PAS) – LPN's , RN's & Respite, based on the full-time equivalent (FTE) calculations developed by the Department
VS-Vendor Services HOME DELIVERED MEALS PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) TELECARE HOME ADAPTATION ASSISTIVE TECHNOLOGY PEST ERADICATION	A choice of two (2) Providers in the county who are accepting new participants.

Specialty	Access Requirement
VEHICLE MODIFICATION NON-MEDICAL TRANSPORTATION	
LTSS Providers – all others not listed.	For the following Provider types, the CHC-MCO must ensure a choice of at least two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

LTSS Access Standards

Initiation of Services - When new Personal Assistance, Home Adaptations, and Assistive Technology services are authorized or services are increased via inclusion on a Participant's PCSP, the new service or increased service level must commence within seven (7) business days of the approval, unless the Participant requests a longer timeframe for the services to start.

Non-Medical Transportation Services - The CHC-MCO must provide 86% of requested non-medical transportation trips.

Covering Providers

PCPs and Specialty Physicians must arrange for coverage with another Provider during scheduled or unscheduled time off, preferably with another PA Health & Wellness network Provider. In the event of unscheduled time off, please notify Provider Services department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a PA Health & Wellness network Provider, he/she will be paid as a non-participating Provider.

Telephone Arrangements

PCPs, Specialists, and Providers must:

- Answer the Participant's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a Participant
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special Participant needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
    - Same day for non-symptomatic concerns

- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a Provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the Participant's medical record

NOTE: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to Participant receiving urgent or emergent care.

PA Health & Wellness will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24-Hour Access

PA Health & Wellness PCPs and Specialty Physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to Participants as needed 24 hours a day, 365 days a year as follows:

- A Provider's office phone must be answered during normal business hours
- During after-hours, a Provider must have arrangements for one of the following:
    - Access to a covering physician
    - An answering service
    - Triage service
    - A voice message that provides a second phone number that is answered
    - Any recorded message must be provided in English and Spanish, if the Provider's practice includes a high population of Spanish speaking Participants

Examples of unacceptable after-hours coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours
- The Provider's office telephone is answered after-hours by a recording that tells patients to leave a message
- The Provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed
- A Clinician returning after-hours calls outside 30 minutes

The selected method of 24-hour coverage chosen by the Participant must connect the caller to someone who can render a clinical decision or reach the PCP or Specialist for a clinical decision. Whenever possible, the PCP, Specialty Physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

PA Health & Wellness will monitor Providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by PA Health & Wellness Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential Provider and Participant information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information protected health information (PHI). “Individually identifiable health information,” including demographic data, is information that relates to:

- The individual’s past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of healthcare to the individual
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Many common identifiers (e.g., name, address, birth date, social security number)

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the family educational rights and privacy act, 20 u.s.c. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of PA Health & Wellness.

Release of data to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Participants or releases required by court order, subpoena, or law.

Participant Privacy Rights

PA Health & Wellness privacy policy assures that all Participants are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. PA Health & Wellness’ privacy policy conforms with 45 c.f.r. (code of federal regulations): relevant sections of the HIPAA that provide Participant privacy rights and place restrictions on uses and disclosures of protected health information (PHI) (§164.520, 522, 524, 526, and 528).

PA Health & Wellness’ policy also assists our personnel and Providers in meeting the privacy requirements of HIPAA when Participants or authorized representatives exercise privacy rights through privacy request including:

Use and Disclosure Guidelines
PA Health & Wellness is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations
A privacy request may be subject to specific limitations or restrictions as required by law. PA Health & Wellness may deny a privacy request under any of the following conditions:

- PA Health & Wellness does not maintain the records containing the PHI
- The requester is not the Participant and we're unable to verify his/her identity or authority to act as the Participant's authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the Participant or another person
- PA Health & Wellness is not required by law to honor the particular request (e.g., accounting for certain disclosures)
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA

Cultural Competency

Cultural Competency within PA Health & Wellness is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

PA Health & Wellness will ensure that inclusiveness and fairness are a part of all of our activities. We will be proactive in our efforts to extend our services and programs to our Limited English Proficiency (LEP) Participants.

PA Health & Wellness will ensure compliance with the following statues and regulations to ensure eligible Participants have equal access to quality health care regardless of their race, color, creed, national origin, religion, disability, or age: Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); and The Age discrimination of 1975 (which prohibits discrimination on the basis of age).

All subcontracts with providers of health care will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964.

Evidence of coverage for all lines of business will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964. PA Health & Wellness is committed to the development, strengthening, and sustaining of healthy Provider/Participant relationships. Participants are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, Participants are at risk for sub-optimal care. Participants may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a Participant begins at the front door. Failure to use Culturally Competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance
- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

PA Health & Wellness will evaluate the Cultural Competency level of its network Providers and provide access to training to assist providers in developing Culturally Competent and culturally proficient practices. Training resources can be located in the Provider Training section of our website. Network Providers must ensure:

- Participants understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. Participants or their representatives may request an interpreter be assigned to accompany them to any covered service. When the Participant has identified the need to have an interpreter accompany them to their appointment, the PA Health & Wellness Participant Services Representative can make the arrangements for the Participant with the designee vendor. Recipients or their representatives can contact Participant Services for a list of translation vendors in their area. Participant Services can access the use of the Language Services, TDD telephone line or the hearing-impaired relay service to assist in this matter.
- Medical care is provided with consideration of the Participant’s race/ethnicity and language

and its impact/influence on the Participant's health or illness.

- Office staff that routinely interact with Participants have access to and participate in Cultural Competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language information from the Participant. Staff will also explain race/ethnicity categories to a Participant so that the Participant is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the Participant's race, country of origin, native language, social class, religion, mental and physical abilities, heritage, culture, age, gender, sexual orientation, and other characteristics that may influence the Participant's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the Pennsylvania Department of Health.
- In order to help us deliver more culturally sensitive care by better understanding our provider demographics, providers may contact Provider Services at 1-844-626-6813 to let us know the languages in which you are fluent, what language services are available through your practice, or your race and ethnicity.
- To obtain an interpreter for a PA Health & Wellness participant, call Participant Services at 1-844-626-6813. Participants have access to interpreter services 24/7, at no cost to them.

The road to developing a Culturally Competent practice begins with the recognition and acceptance of the value of meeting the needs of the patients. PA Health & Wellness is committed to helping each Provider reach this goal. The following questions should be considered as care is provided to PA Health & Wellness Participants:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to advance health equity at every point of contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs or activities of a public entity.
- Discrimination by any such entity.

Providers should ensure that their offices are as accessible as possible to persons with disabilities.

Providers are required to comply with ADA accessibility guidelines. PA Health & Wellness must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

If the office or facility is not accessible under the terms of this paragraph, the office or facility may participate in the Provider Network provided that the office or facility: 1) Requests and is determined by PA Health & Wellness to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) Agrees, in writing, to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred eighty (180) days after PA Health & Wellness has identified the barrier.

Providers should also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways. PA Health & Wellness offers sign language and telephonic interpreter services at no cost to the Provider or Participant. Call your Provider Relations Representative at 1-844-626-6813 for more information.

Reporting Suspected Abuse and Neglect

All PA Health & Wellness Providers and their employees and administrators of a facility are mandatory reporters of suspected physical and/or sexual abuse and neglect of PA Health & Wellness Participants. This requirement is further detailed under the Older Adult Protective Services Act and the Adult Protective Service Act. These laws have been established in order to detect, prevent, reduce, and eliminate, abuse, neglect, exploitation and abandonment of adults in need including PA Health & Wellness Community HealthChoices Participants. If you suspect elder abuse or the abuse of an adult with a disability call Adult Protective Services at 1-800-490-8505, available 24 hours a day. Following an examination for suspected abuse or neglect, should a Network PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS of OAPS representative on how to access mental health services and coordinate access to these services when necessary.

Abuse is defined by 6 PA Code § 15.2 as one or more of the following acts: a) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish b) the willful deprivation by a caretaker of goods or services necessary to maintain physical or mental health c) sexual harassment, rape, or abuse. Sexual abuse of a participant is defined as intentionally, knowingly, or recklessly causing or attempting to cause the rape of involuntary sexual intercourse with, sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest with a Participant.

Neglect is the failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health.

Common Signs of Abuse:

- Bruises or broken bones
- Weight loss
- Memory loss
- Personality changes
- Social isolation
- Changes in banking habits
- Giving away assets such as money, property, etc.

For further information, please refer to the DHS website at http://dhs.pa.gov/.

Mainstreaming

PA Health & Wellness considers mainstreaming of its Community HealthChoices Participants an important component of the delivery of care and expects participating Providers to treat Participants without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, gender identity, sexual preference, language, MA status, disease or pre-existing condition, health status, income status, program participantship or physical or behavioral disabilities, except where medically indicated. Examples of prohibited practices are:

- Denying a Participant a covered service or availability of a facility
- Providing a PA Health & Wellness Participant a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay patients (examples: different waiting rooms or appointment times or days)

Advance Directives

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult Participants written information about the Participants' right to have an Advance Directive. An Advance Directive is a legal document through which a Participant may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Participants can use Advance Directives when the Participant is unable to make or communicate decisions about his or her medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the Participant to be unable to actively make a decision about his or her medical care.

In Pennsylvania, there are two types of Advance Directives:

- Living will or health care instructions

- Appointment of a Health Care Power of Attorney

PA Health & Wellness is committed to ensure that Participants are aware of and are able to avail themselves of their rights to execute Advance Directives. PA Health & Wellness is equally committed to ensuring that its Providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

PA Health & Wellness Service Coordinators and Care Management staff will provide and/or ensure that network practitioners are providing written information to all adult Participants receiving medical care with respect to their rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Advance Directives are addressed by the treating physician with the Participant during an office visit. Neither PA Health & Wellness nor Providers will condition the authorization or provision of care or otherwise discriminate against a Participant based on whether or not the Participant has executed an Advance Directive. PA Health & Wellness will facilitate communications between a Participant or Participant's representative and the Participant's Provider if/when the need is identified to ensure that they are involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.

PA Health & Wellness is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. To do this, PA Health & Wellness will annually assess and document the Advance Directive status in the Case Management systems.

PCPs and Providers delivering care to PA Health & Wellness Participants must ensure adult participants receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document such information in the permanent medical record.

PA Health & Wellness recommends to its PCPs and physicians that:

- The first point of contact for the Participant in the PCP's office should ask if the Participant has executed an Advance Directive and the Participant's response should be documented in the medical record.
- If the Participant has executed an Advance Directive, the first point of contact should ask the Participant to bring a copy of the Advance Directive to the PCP's office and document this request in the Participant's medical record.
- An Advance Directive should be a part of the Participant's medical record and include mental health directives.

If an Advance Directive exists, the physician should discuss potential medical emergencies with the Participant and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Provider Responsibility

Providers must comply with federal and state laws regarding Advance Directives (also known as health care power of attorney and living wills). Providers must also comply with contractual requirements for

adult Participants. PA Health & Wellness requires that Providers obtain and maintain Advance Directive information in the Participant's medical record. Requirements for Providers include:

- Maintaining written policies that address a Participant's right to make decisions about their medical care, including the right to refuse care.
- Providing Participants with written information about Advance Directives.
- Documenting the Participant's Advance Directives, or lack of, in his or her medical record.
- Communicating the Participant's wishes to attending staff in hospitals or other facilities.
- Not discriminating against a Participant or making treatment conditional on the basis of his or her decision to have or not have an Advance Directive.
- Providing staff education on issues related to Advance Directives.

Participants can file complaints or grievances concerning noncompliance with Advance Directive requirements with PA Health & Wellness and/or with the Pennsylvania Department of Human Services. PA Health & Wellness provides information about Advance Directives to Participants in the Participant Handbook, including the Participant's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney, and general instructions.

For more information or to communicate complaints regarding noncompliance with Advance Directive requirements, contact:

Pennsylvania Office of Attorney General Strawberry Square
16th Floor Harrisburg, PA 17120
Phone: 717-787-3391

Primary Care Practitioner (PCP)

The Primary Care Practitioner (PCP) is a specific physician, physician group or a CRNP operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing Primary Care Service; locating, coordinating and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a Participant. PCPs are the cornerstone of PA Health & Wellness service delivery model. The PCP serves as the "Medical Home" for the Participant. The Medical Home concept assists in establishing a Participant/Provider relationship, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

PA Health & Wellness offers a robust network of primary care Providers to ensure every Participant has access to a Medical Home within the required travel distance standards (urban areas 2 within 30 minutes of each Participant's home and rural 2 within 60 minutes of each Participant's home).

PA Health & Wellness requires PCPs, dentists, and Specialists to conduct affirmative outreach whenever a Participant misses an appointment and to document this in the medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the Participant. Attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve as PCPs

Specialty types who may serve as PCPs include:

- Family Practitioner
- Federally Qualified Health Center (FQHC)
- General Practitioner
- Internist
- Pediatrician
- Physician Assistant
- Obstetrician or Gynecologist (OB/GYN)
- Rural Health Center (RHC)

Specialists as PCPs

Participants with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Participant, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide specialty medical services consistent with the participant's disabling condition, chronic illness or special healthcare needs in accordance with the PCP responsibilities included in this manual.

Participant Panel Capacity

All PCPs reserve the right to determine the number of Participants they are willing to accept into their panel. PA Health & Wellness **does not** guarantee any Provider will receive a certain number of Participants. The PCP to participant ratio shall not exceed 1,000 Participants to a single PCP.

PCPs interested in exceeding the Participant limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional Participants. This ratio applies to all MCOs.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact PA Health & Wellness Provider Services at 1-844-626-6813. A PCP shall not refuse to treat Participants as long as the physician has not reached their requested panel size.

Providers shall notify PA Health & Wellness in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under PA Health & Wellness agreements. In no event shall any established patient who becomes a PA Health & Wellness Participant be considered a new patient.

PCP Assignment

PA Health & Wellness Participants have the freedom to choose a PCP from our comprehensive Provider network. Within 15 days of enrollment, PA Health & Wellness will send new Participants a letter encouraging them to select a PCP. For those Participants who have not selected a PCP during enrollment or within 30 calendar days of enrollment, PA Health & Wellness will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns participants to a PCP according to the following criteria:

1. Participant's geographic location
2. Participant's previous PCP, if known
3. Other family members' PCPs, if known
4. Special healthcare needs, including pregnancy, if known

5. Special language and cultural considerations, if known

Primary Care Practitioner (PCP) Responsibilities

PA Health & Wellness will monitor PCP actions for compliance with the following responsibilities. PCP responsibilities include, but are not limited to, the following:

- Providing primary and preventive care, acting as the Participant's advocate, and providing, recommending, and arranging for services.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each Participant's healthcare
- Communicating effectively with the Participant by using specialized interpretive services for Participants who are deaf and blind, and oral interpreters for those Participants with LEP when needed. Interpreter services must be free of charge to the Participant and the PCP cannot require family members to be used for interpretation.
- Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.
- Maintaining a current medical and other service record for the Participant, including documentation of all services provided to the Participant by the PCP, as well as any specialty or referral services.
- Coordinating BH Services by working with BH-MCOs as specified in Exhibit H, Coordination with the BH-MCOs.
- Allow PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs

Specialist Responsibilities

PA Health & Wellness encourages Specialists to communicate to the PCP the need for a referral to another Specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the Participants' care and ensure the referred Specialty physician is a participating Provider within the PA Health & Wellness network and that the PCP is aware of the additional service request. The Specialty physician may order diagnostic tests without PCP involvement by following PA Health & Wellness referral guidelines.

Emergency admissions will require notification to PA Health & Wellness' Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require Prior Authorization from PA Health & Wellness.

The Specialist Provider must:

- Maintain contact with the PCP.
- Obtain authorization from PA Health & Wellness Medical Management department if needed before providing services.
- Coordinate the Participant's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of Participant care.
- Maintain the confidentiality of medical information.
- Allow PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

PA Health & Wellness Providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both PA Health & Wellness and the Provider in the Provider contract.

The PA Health & Wellness requires PCPs, Dentists, and Specialists to conduct affirmative outreach whenever a Participant misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Participant. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

Hospital Responsibilities

PA Health & Wellness utilizes a network of Hospitals to provide services to PA Health & Wellness Participants. Hospital Services Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the RFP.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the Participant's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify PA Health & Wellness Medical Management department by sending an electronic file of the ER admission within 24 hours or the next business day. The electronic file should include the Participant's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and Participant's phone number.
- Notify PA Health & Wellness Medical Management department of all admission within one

business day.

- Notify PA Health & Wellness Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

Long-Term Services and Supports Provider Responsibilities

The LTSS Provider is required to adhere to the following responsibilities:

- Provide PA Health & Wellness Participants with a professionally recognized level of care and efficiency consistent with community standards, consistent with the Health Plan's clinical and non-clinical guidelines and within the practice of your professional license
- Abide by the terms of the Participating Provider Agreement
- Comply with all plan policies, procedures, rules and regulations, including those found in this manual
- Maintain confidential medical records consistent with PA Health & Wellness' medical records standards, medical record keeping guidelines, and applicable HIPAA regulations
- Maintain a facility that promotes enrollee safety
- Participate in PA Health & Wellness's quality improvement program initiatives
- Participate in Provider orientations and continuing education
- Abide by the ethical principles of your profession
- Notify the plan if you are undergoing an investigation, or agree to written orders by the state licensing agency
- Notify the plan if there is a change of status with Participant eligibility
- Ensure you have staff coverage to maintain service delivery to Participants
- Allow PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs

New Provider Orientation

Providers are required to complete a new provider orientation within 30 days of an executed contract. This is our opportunity to welcome you to the network and make sure you have all the tools and knowledge to best work with PA Health & Wellness. For more information on your New Provider Orientation requirements or materials, please contact your Provider Network Specialist or **ProviderTraining@PAHealthWellness.com**.

Voluntarily Leaving the Network

Providers must give PA Health & Wellness notice of voluntary termination following the terms of their participating agreement with our Health Plan. In order for a termination to be considered valid, Providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, Providers must supply copies of medical records to the Participant's new Provider upon request and facilitate the Participant's transfer of care at no charge to PA Health & Wellness or the Participant.

PA Health & Wellness will notify affected Participants in writing of a Provider's termination, within 15 calendar days of the receipt of the termination notice from the Provider, provided that such notice from the Provider was timely.

Providers must give PA Health & Wellness 60 day's prior written notice of voluntary termination following the terms of their participating agreement with our Health Plan.

BENEFIT EXPLANATIONS AND LIMITATIONS

PA Health & Wellness network Providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 1-844-626-6813. A Provider Service Representative will be happy to assist you.

PA Health & Wellness covers, at a minimum, those core benefits and services specified in our Agreement with Pennsylvania State Medicaid and defined in the administrative rules and Department policies and procedure handbook.

Covered Services

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

CHC Covered Physical Health Services	
Inpatient Hospital Services • Inpatient Acute Hospital • Inpatient Rehab Hospital	**Clinic Services** • Independent Clinic • Maternity – Physician,

Outpatient Hospital Clinic Services • Outpatient Hospital Clinic • Outpatient Hospital Short Procedure Unit • Federally Qualified Health Center / Rural Health Clinic	Certified Nurse Midwives, Birth Centers • Renal Dialysis Services • Ambulatory Surgical Center (ASC) Services
Dental Services	**Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders**
Other Laboratory and X-ray Service • Laboratory • Radiology (For example: X- rays, MRIs, CTs)	**Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist** • Prescribed Drugs • Dentures • Prosthetic Devices • Eyeglasses
Nursing Facility Services • Skilled Nursing Facility	
Family Planning Clinic Services, and Supplies	**Diagnostic, Screening, Preventive, and Rehabilitative Services** • Tobacco Cessation • Therapy (Physical, Occupational, Speech) - Rehabilitative
Physician Services • Primary Care Provider • Physician Services and Medical and Surgical Services provided by a Dentist	**Certified Registered Nurse Practitioner Services**
Medical care and any other type of Remedial Care • Podiatrist Services • Optometrist Services • Chiropractor Services • Home Health Services • Home Healthcare Including Nursing, Aide and Therapy • Medical Supplies • Durable Medical Equipment	**Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary** • Ambulance Transportation • Non-Emergency Medical Transport • Emergency Room • Hospice Care • *Limited Abortions

Therapy (Physical, Occupational, Speech)	**Definitions for Physical Health Services may be found in the Pennsylvania Medicaid State Plan at: http://www.dhs.pa.gov/publications/medicaidstateplan/**
Community HealthChoices LTSS Benefits	
Adult Daily Living	Job Coaching
Assistive Technology	Job Finding
Behavior Therapy	Nursing
Benefits Counseling	Non-Medical Transportation
Career Assessment	Nursing Facility Services
Cognitive Rehabilitation	Nutritional Counseling
Community Integration	Participant-Directed Community Supports
Community Transition Services	Participant-Directed Goods and Services
Counseling	Personal Assistance Services
Employment Skills Development	Personal Emergency Response System
Exceptional DME	Pest Eradication
Financial Management Services	Residential Habilitation
Home Adaptations	Respite
Home Delivered Meals	Specialized Medical Equipment and Supplies
Home Health Services • Home Health Aide Services • Nursing Services • Physical Therapy • Occupational Therapy • Speech and Language Therapy	Structured Day Habilitation TeleCare Therapeutic and Counseling Services Vehicle Modifications

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

Definitions for the LTSS listed above can be found in the 1915(c) Home and Community Based Services Waiver, as may be amended from time to time, found at: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_264258.pdf

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

Sterilization

Sterilization procedures, such as tubal ligation and vasectomy, are covered when coordinated through a PCP and delivered by a network Provider. As a Provider, you must counsel the Participant regarding

alternative methods of birth control that are available. The sterilization procedure is permanent, and the surgery cannot be 100% guaranteed to make him/her sterile. Inform the Participant that the signed consent can be withdrawn at any time and that he/she will not lose any health services or benefits.

The Participant must be at least 21 years of age, mentally competent, and not in an institution at the time he/she voluntarily signs the consent form. The Participant must give informed consent and sign the **Sterilization Consent Form (MA-31)** **(Spanish Version)** at least 30 days, but no more than 180 days, before the procedure in order to receive coverage.

Abortion

An abortion is only covered in cases where the mother's life is in danger or pregnancy is the result of rape or incest.

The physician requesting authorization of coverage for an abortion must complete the **Physician Certification for an Abortion Form (MA-3)** **(Spanish Version)** prior to performing the procedure. The signed consent form must be submitted with the claim to obtain payment.

Hysterectomy

Hysterectomy surgery is covered when it is considered medically necessary and performed by a network Provider. The Provider and Participant must complete the **Patient Acknowledgement for Hysterectomy Form (MA-30)** prior to performing the procedure. The consent form must accompany the claim to obtain payment.

School-Based Services

School-based health services provide basic health services and offer specific school programs to promote a healthy lifestyle. PA Health & Wellness Special Needs Unit will work with parents/guardians, school districts, community centers, and the PCP to provide these programs.

Non-Emergent Medical Transportation

For medically necessary non-emergent transportation requested by the Participant or someone on behalf of the Participant, PA Health & Wellness will require the transportation Provider to schedule transportation so that the Participant arrives on time, but no sooner than one hour before the appointment. The Participant will not have to wait more than one hour after the conclusion of the treatment for transportation home. PA Health & Wellness requests its participating Providers, including the transportation vendor, inform our Participant Services department when a Participant misses a transportation appointment. When notified of missed appointments, PA Health & Wellness can monitor and educate the Participant on the importance of keeping medical appointments.

Women's Health Care

If the Participant's PCP is not a women's health Specialist, PA Health & Wellness will provide direct access to a network Specialist for core benefits and services necessary to provide women routine and preventive health care. Participants are allowed to utilize their own PCP or any family planning service Provider for family planning services without the need for a referral or a prior authorization.

In addition, Participants will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services. In situations where a new Participant is pregnant and already receiving care from an out-of-network OB/GYN Specialist at the time of enrollment, the Participant may continue to receive services from that Specialist throughout the pregnancy and postpartum care related to the delivery.

PA Health & Wellness will make every effort to contract with all local family planning clinic and Providers and will ensure reimbursement whether the Provider is participating or out-of-network.

LTSS Service Definitions

Adult Daily Living

Adult Daily Living services are designed to assist Participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the Participant. Adult Daily Living includes two (2) components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A, and 11.123 Core Services (Older Adult Daily Living Center or OADLC Regulations § 11.123 (2)), the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for Participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The Participant's service plan initiates and directs the services they receive while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

- Nursing Services: In addition to the requirements found in the OADLC Regulations §11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver Participant. At a minimum, each waiver Participant must be observed every other week by the RN with the appropriate notations recorded in the Participant's service plan, with the corresponding follow-ups being made with the Participant, family, or physician.
- Staff to Participant Ratio of 1:5.
- Operating Hours: open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday.
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.

- Adult Daily Living providers that are certified as Enhanced receive the Enhanced full day or Enhanced half day rate for all Participants attending the Enhanced center.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits. This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable settings for home and community-based waiver services. Services can be provided as either a full day or half day. Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day.

Assistive Technology

Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment. The service is intended to ensure the health, welfare and safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities. All items shall meet the applicable standards of manufacture, design and installation. Assistive Technology is limited to:

- Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for Participants.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings.
- Training or technical assistance for the Participant, paid caregiver and unpaid caregiver.
- An independent evaluation of the Assistive Technology needs of a Participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the Participant in his/her customary environment.
- Extended warranties.
- Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist Participants with a need identified through the evaluation described below.

If the Participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the Participant's behavior support plan or Speech, Occupational or Physical Therapy service. Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. This service excludes those items that are not of direct medical or remedial benefit to the Participant. Recreational items are also excluded.

Benefits Counseling

Benefits Counseling is a service designed to inform, and answer questions from, a Participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc. The service also will provide information and education to the Participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking competitive integrated employment or career advancement.

Benefits Counseling may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. Initial Benefits Counseling may only be provided if it is documented in the service plan that Benefits Counseling services provided by a Certified Work Incentives Counselor through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought, and it was determined that such services were not available either because of ineligibility or because of wait lists that would result in services not being available within 30 calendar days.

Career Assessment

Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the Participant. Services support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community, and ensure the health, welfare and safety of the Participant.

Career Assessment is an individualized employment assessment that includes:

- Conducting a review of the Participant's work and volunteer history, interests and skills, which may include information gathering or interviewing.
- Conducting situational assessments to assess the Participant's interest and aptitude in a particular type of job.
- Identifying types of jobs in the community that match the Participant's interests, strengths and skills.
- Developing a Career Assessment Report that specifies recommendations regarding the Participant's needs, interests, strengths, and characteristics of potential work environments. The Career Assessment Report must also specify training or skills development necessary to achieve the Participant's employment or career goals that could be addressed by other waiver services in the Participant's service plan.

This service includes Discovery for individuals whose, due to the impact of their disability, skills,

preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments that compare the individual to others or arbitrary standards of performance and/or behavior. Discovery involves a comprehensive analysis of the person in relation to following:

- Strongest interests toward one or more specific aspects of the labor market
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment
- Conditions necessary for successful employment or self-employment

Discovery includes the following activities: observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

Career Assessment services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. This means that Career Assessment services may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the Participant or has stopped providing services to the Participant
2. The Participant was determined ineligible for OVR services
3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA

Documentation in accordance with Department requirements must be maintained in the file by the Supports Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the Participant under other federal programs.

Career Assessment does not include supports to continue paid or volunteer work once it is obtained. Career Assessment services may only occur once per service plan year and payment will be made only for a completed assessment.

Community Integration

Community Integration (CI) is a short-term, goal-based support service designed to assist Participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community Integration can include cueing and on-site

modeling of behavior to assist the Participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a Nursing Facility, moving to a new community or from a parent's home, or a change in condition that requires new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the Participant's service plan. Services must be provided at a 1:1 ratio.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the Participant to assure that expected outcomes are met and the service plan is modified accordingly. The length of service should not exceed thirteen (13) weeks on new plans. If the Participant has not reached the goal at the end of (thirteen) 13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the PCSP at the time of the quarterly review. If the Participant has not reached his/her Community Integration goals by the end of twenty-six (26) weeks, the goals need to change, or it is concluded that the individual will not independently complete the goal and the Service Coordinator must assess for a more appropriate service to meet the Participant's need. Each distinct goal may not remain on the PCSP for more than twenty-six (26) weeks. No more than 32 units per week for one Community Integration goal will be approved in the PCSP. If the Participant has multiple CI goals, no more than 48 units per week will be approved in the PCSP.

Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services.

Community Transition Services

Community Transition Services are one-time expenses for Participants that make the transition from an institution to their own home, apartment or family/friend living arrangement. Community Transition Services may be used to pay the necessary expenses for a Participant to establish his or her basic living arrangement and to move into that arrangement. Expenses that may be incurred include:

- Equipment, essential furnishings, and initial supplies. Examples are household products, dishes, chairs, tables.
- Moving Expenses.
- Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement.
- Set-up fees or deposits for utility or service access. Examples are telephone, electricity, heating.
- Items for personal and environmental health and welfare. Examples are personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy.

Excluded items include:

- Ongoing payment for rent or mortgage expenses.

- Food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.
- Supports or activities provided to obtain the items.
- Services available under Assistive Technology, Home Adaptations, and Specialized Medical Equipment and Supplies.
- Community Transition Services are limited to an aggregate of $4,000 per Participant, per lifetime.

Employment Skills Development

Employment Skills Development services provide learning and work experiences, including volunteer work, where the Participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the PCSP, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

Employment Skills Development services are designed to:

- Be individually tailored to directly address the Participant's employment goals as identified in the needs assessment and included in the service plan. If the Participant has received a Career Assessment that has determined that the Participant is in need of acquiring particular skills in order to enhance their employability, those identified skills development areas must be addressed within the participant's service plan and by the Employment Skills Development service.
- Enable each Participant to attain the highest level of work in the most integrated setting and with the job matched to the Participant's career goals, interests, strengths, priorities, abilities and capabilities, while following applicable federal and State wage guidelines.
- Support acquisition of skills needed to obtain competitive, integrated employment in the community.
- Develop and teach general, translatable skills including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources.
- Provide and support the acquisition of skills necessary to enable the participant to obtain competitive, integrated work where the compensation for the participant is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by participants without disabilities, which is considered to be the optimal outcome of Employment Skills Development services.

Support may be provided to Participants for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Skills Development as a part of placement and training may occur as a one-to-one training experience or in a group setting in accordance with Department

requirements.

Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer or training activity. Employment Skills Development may be provided in facilities licensed under Pa. Code Chapter 2390, but only after the Participant has been referred to OVR and the following is documented: the Participant was either determined ineligible by OVR or their OVR case is closed, and the provision of Employment Skills Development services has already been attempted in a competitive, integrated employment setting or an unlicensed community-based setting outside the participant's home.

Participants receiving Employment Skills Development services must have measurable employment-related goals in their service plan.

Services must be delivered in a manner that supports the Participant's communication needs including, but not limited to, age-appropriate communication, translation services for Participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the Provider's understanding and use of communication devices used by the Participant.

If the Participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

The Employment Skills Development Service Provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the training objectives are being met.

Handicapped employment, as defined in 55 Pa. Code Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where Participants are supervised in producing goods or performing services under contract to third parties.

Exceptional Durable Medical Equipment (DME)

Exceptional DME is defined as DME that has an acquisition cost of $5,000 or more and is either Specially Adapted DME or other DME that is designated as exceptional DME by the Department annually by notice in the Pennsylvania Bulletin. Exceptional DME can either be purchased or rented. In the event of an Exceptional DME purchase, the equipment will belong to the Participant.

"Specially Adapted DME" is DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one resident, making its contemporaneous use by another resident unsuitable.

The list of Exceptional DME that has been designated by the Department is as follows:

(1) Air fluidized beds. The pressure relief provided by this therapy uses a high rate of airflow to fluidize fine particulate material (for example, beads or sand) to produce a support medium

that has characteristics similar to liquid. May have a Gortex cover.

a. Powered air flotation bed (low air loss therapy). A semi-electric or total electric bed with a fully integrated powered pressure-reducing mattress which is characterized by all of the following: An air pump or blower with a series of interconnected woven fabric air pillows which provides sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress allowing some air to escape through the support surface to the resident. May have a Gortex cover.

b. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater.

c. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses) and air pressure provide adequate patient lift, reducing pressure and prevent bottoming out.

d. A surface designed to reduce friction and shear.

e. May be placed directly on a hospital bed frame.

f. Automatically readjusts inflation pressures with change in position of bed (for example, head elevation, and the like).

(2) Augmentative communication devices. Used by residents who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the resident and the resident must demonstrate the abilities or potential abilities to use the device selected. Portable devices need to supplement, aid or serve as an alternative to natural speech for residents with severe expressive communication disorders. Nonportable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.

(3) Ventilators (and related supplies) used by residents 21 years of age and older who require full ventilator support for a minimum of 8 hours per day to sustain life. A Ventilator Authorization allows exceptional payments under specific terms to a Nursing Facility, in addition to the Nursing Facility's per diem rate, for Nursing Facility services that are provided for the use of certain ventilator supplies. The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the Ventilators and related supplies specified in the agreement with the Nursing Facility.

Financial Management Services

Financial Management Services (FMS) include fiscal-related services to Participants choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for Participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the Participant's PCSP are managed and disbursed appropriately as authorized. The FMS Provider must operate as either a qualified Vendor Fiscal/Employer Agent (F/EA) or as a qualified Government Fiscal/Employer Agent (F/EA). The F/EA must:

- Have an FMS policies and procedures manual, that includes the policies, procedures and internal controls that describe the proper operation of the F/EA, which are in accordance with federal, state, and local tax, labor, workers compensation and program rules and regulations.

- Enroll Participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the Participant.
- Provide orientation and skills training to Participants on required documentation for all directly hired support workers, including the completion of federal and State forms; the completion of timesheets; good hiring and firing practices; establishing work schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation.
- Conduct criminal background checks and when applicable, child abuse clearances, on potential employees.
- Distribute, collect and process support worker timesheets as verified and approved by the Participant.
- Prepare and issue support workers' payroll checks, as approved in the Participant's PCSP.
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations.
- Broker workers' compensation for all support workers through an appropriate agency.
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws.
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
- Assist in implementing the state's quality management strategy related to FMS.
- Establish an accessible customer service system for the Participant and the Service Coordinator.
- Assist Participants in verifying support workers citizenship or alien status.
- Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only).
- Provide written financial reports to the Participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the Participant, Service Coordinator, and OLTL.

FMS is reimbursed on a per-participant per-month basis with a one-time start-up fee for all new Participants that enroll for FMS. The one-time start-up fee applies to new Participants and will only be paid once in a lifetime per Participant. The initial start-up fee covers the lengthy process of enrolling Participants as a common law employee. The one-time start- up fee and the ongoing per-participant per-month service fee may not be billed simultaneously.

Home Adaptations

Home Adaptations are physical adaptations to the private residence of the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant, and enable the Participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations. Wheelchair lifts, stair glides, ceiling lifts, and metal accessibility ramps are covered by the State Plan, along with installation of the equipment and require a script. Home Adaptations to a household are limited to the following:

- Installation of specialized electric and plumbing systems that is necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the Participant.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/carbon monoxide for Participants with sensory impairments.
- Outside railing to safely access the home.
- Widened doorways, landings and hallways.
- Swing-clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Slip-resistant flooring.
- Kitchen counter, sink and other cabinet modifications (including brackets for appliances).
- Bathroom adaptations for bathing, showering, toileting and personal care needs.
- Raised electrical switches and sockets.
- Other adaptations, subject to approval, to address specific assessed needs as identified in the service plan.

All adaptations to the home shall be provided in accordance with applicable building codes. Home Adaptations shall meet standards of manufacture, design and installation. Home Adaptations must be an item of modification that the family would not be expected to provide to a family participant without a disability or specialized needs. Materials and equipment must be based on the Participant's need as documented in the PCSP. All adaptations to the home for accessibility require homeowner consent.

This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech language pathologist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to Provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home adaptations must be obtained at the lowest cost.

Building a new room is excluded. Specialized Medical Equipment and Supplies are excluded. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant, which includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom.

Rented property adaptations must meet the following:

- There is a reasonable expectation that the Participant will continue to live in the home.
- Written permission is secured from the property owner for the adaptation.
- The landlord will not increase the rent because of the adaptation.
- There is no expectation that waiver funds will be used to return the home to its original state.

This service may not be included on the same service plan as Residential Habilitation.

Home Delivered Meals

The Home Delivered Meals service provides meals that meet at least one-third (1/3) of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. Participants may receive more than one meal per day, but they cannot receive meals that constitute a "full nutritional regimen" (three meals per day).

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods.
- Can either be a hot, cold, frozen or shelf-stable meal.

Home Delivered Meals are provided only during those times when neither the Participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision. Meals provided as part of this service shall not constitute a full nutritional regimen (three meals per day). Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.

Home Health Services

Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. Home Health Aide Services

Home Health Aide services are direct services prescribed by a physician to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. The physician's order must be obtained every sixty (60) days for continuation of service. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the Participant's situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a Participant's medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist Home Healthcare Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

2. Nursing Services

Nursing services are direct services prescribed by a physician that are needed by the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant.

Nursing services are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. The physician's order must be obtained every sixty (60) days for continuation of service. Nursing services are individual, and can be continuous, intermittent, or short-term based on individual's assessed need.

3. Physical Therapy

Physical Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Physical Therapy can be provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and in accordance with the Physical Therapy Practice Act (63 P.S. §1301 et seq.).

4. Occupational Therapy

Occupational Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. Occupational Therapy services can be provided by a licensed occupational therapist or an occupational therapist assistant in accordance with the Occupational Therapy Practice Act (63 P.S. §1501 et seq.)

5. Speech and Language Therapy

Speech and Language Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services are provided by a licensed American Speech Language Hearing Associate or certified speech-language pathologist in accordance with applicable State standards including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for and adapting and use of augmentative and alternative communication strategies.

Job Coaching

Job Coaching services are individualized services providing supports to Participants who need ongoing support to learn a new job and maintain a job in a competitive employment arrangement in an integrated work setting in a position that meets job and career goals. Participants in a competitive employment arrangement receiving Job Coaching services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job Coaching can also be used to support Participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. Job Coaching provides two components in accordance with an assessment: Intensive Job Coaching and Extended Follow-along.

Intensive Job Coaching includes on the-job training and skills development; assisting the Participant with development of natural supports in the workplace; and coordinating with employers or employees, coworkers and customers, as necessary. Intensive Job Coaching includes assisting the Participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the Participant is employed. Intensive Job Coaching provides support to assist Participants in stabilizing in an integrated situation (including self- employment) and may include activities on behalf of the Participant when the Participant is not present to assist in maintaining job placement. Participants receiving Intensive Job Coaching require on-the-job support for more than twenty percent (20%) of their work week at the outset of the service, phasing down to twenty percent (20%) per week during the Intensive Job Coaching period (at which time, Extended Follow-along will be provided if ongoing support is needed). Job Coaching supports within this range should be determined based on the Participant's needs.

Intensive Job Coaching for the same employment site and/or position may only be authorized for up to 6 months and may be reauthorized for additional 6-month periods, upon review with the service planning team. Intensive Job Coaching may only be reauthorized twice, for a total of 18 consecutive months of Intensive Job Coaching support for the same employment site and/or position. Intensive Job Coaching is recommended for new employment placements or may be reauthorized for the same location after a period of Extended Follow-along, due to change in circumstances (new work responsibilities, personal life changes, etc.).

Extended Follow-along is ongoing support available for an indefinite period as needed by the Participant to maintain their paid employment position once they have been stabilized in their position (receiving less than 20% onsite support for at least four weeks). Extended Follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of Intensive Job Coaching. Once transitioned to Extended Follow-along, Providers are required to make at least two (2) visits per month, up to a maximum of two-hundred forty (240) hours per service plan year. This allows an average of twenty (20) hours per month to manage difficulties which may occur in the workplace and the limit may be used for the participant over an annual basis, as needed. If circumstances require more than that amount per service plan year, the service must be billed as Intensive Job Coaching.

Job Coaching services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the participant. This means that Job Coaching may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the Participant or has stopped providing services to the Participant.

2. The Participant was determined ineligible for OVR services; or

3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Job Coaching does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

Job Coaching does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

Job Finding

Job Finding is an individualized service that assists Participants to obtain competitive, integrated employment paid at or above the minimum wage. Job Finding identifies and/or develops potential jobs and assists the Participant in securing a job that fits the Participant's skills and preferences and employer's needs. If the Participant has received a Career Assessment, the results of that assessment must be addressed within the PCSP and by the Job Finding service.

Job Finding may include customized job development. Customized job development is based on individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the participant, either through task reassignment, job carving, or job sharing. Job Finding, which may include prospective employer relationship building, is time limited. Job Finding requires authorization up to ninety (90) days, with re authorization every (90) days, for up to one (1) year. At each ninety (90) day interval, the PCSP team will meet to clarify employment goals and expectations and review the job finding strategy. The service also includes transportation as an integral component of the service, such as to a job interview, during the delivery of Job Finding.

Job Finding does not include activities covered through Job Coaching once employment is obtained. Job Finding does not include skills training to qualify for a job.

Job Finding services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the participant. This means that job finding may only be provided when documentation has been obtained that

one of the following has occurred:

1. OVR has closed a case for the Participant or has stopped providing services to the Participant;

2. The Participant was determined ineligible for OVR services; or

3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Non-Medical Transportation

Non-Medical Transportation services enable Participants to gain access to LTSS services as specified in the PCSP. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable) and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a Participant and/or the purchase of tickets or tokens to secure transportation for a Participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must be tied to a specific objective identified on the PCSP.

Non-medical Transportation services may only be authorized on the PCSP after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the Participant, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the Participant or another individual when driving the Participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs. Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

Nursing Facility Services

Professionally supervised nursing care and related medical and other health services furnished by a health care facility licensed by the Pennsylvania Department of Health as long-term care nursing facility under Chapter 8 of the Health Care Facilities Act (35 P.S. §§ 448.801—448.821) and certified as a nursing facility provider in the MA Program (other than a facility owned or operated by the state or federal government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed an provided on a regular basis in the context of a planned program or health care and management. A participant must be NFCE to receive nursing facility services under the CHC Program.

Nursing Facility Services includes at least the items and services specified in 42 CFR 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 PA Code § 1187.51.

Participant-Directed Community Supports

Participant-Directed Community Supports will be offered to Participants utilizing budget authority. Participant-Directed Community Supports are specified by the PCSP, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. The Participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the Participant. Services include assisting the Participant with the following:

- Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living.
- Health maintenance activities such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities.
- Improving and maintaining mobility and physical functioning.
- Maintaining health and personal safety.
- Carrying out household chores such as shopping, laundry, cleaning and seasonal chores.
- Preparation of meals and snacks.
- Accessing and using transportation (If providing transportation, the support services worker must have a valid driver's license and liability coverage as verified by the F/EA).
- Participating in community experiences and activities.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services and Participant-Directed Goods and Services.

Participant-Directed Goods and Services

Participant-Directed Goods and Services are services, equipment or supplies limited to Participants that are utilizing Budget Authority for Participant-directed service. Participant- directed goods and services are purchased from the Participant's Individual Spending Plan.

These items must address an identified need in the Participant's traditional service plan (including

improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the Participant.
- Increase the individual's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.
- Increase the ability of unpaid family participants and friends to receive training and education needed to provide support or
- Fulfill a medical, social or functional need as identified in the Participant's PCSP.

Participant-Direct Goods and Services does not include personal items and services not related to the disability, groceries, rent or mortgage payments, entertainment activities, or utility payments; may not be provided at the same time as Home Health Aide Services, Personal Assistance Services, and Participant-Directed Community Supports; and are limited to instances when the Participant does not have personal funds to purchase the item or service and the item or service is not available through another source.

Personal Assistance Services

Personal Assistance Services primarily provide hands-on assistance to Participants that are necessary, as specified in the PCSP, to enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's PCSP. Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include Care to assist with activities of daily living (e.g., eating, bathing, dressing, and personal hygiene), cueing to prompt the Participant to perform a task, and providing supervision to assist a Participant who cannot be safely left alone. Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's PCSP and permitted under applicable State requirements. Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the Participant. Assistance and implementation of prescribed therapies. Overnight Personal Assistance Services provide intermittent or ongoing awake, overnight assistance to a Participant in their home for up to eight hours. Overnight Personal Assistance Services require awake staff.

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living: Activities that are incidental to the delivery of Personal Assistance include services such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.

Services, as documented in the PCSP, to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing

assistance with any of the activities noted above to enable the completion of those tasks.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services and Section 12006(a) of the 21st Century Cures Act, Section 1903(1) to the Social Security Act, 42 U.S.C. § 1396(b)(1), which mandates EVV use. NFCE Participants who are residing in Personal Care Homes as of the Implementation Date will be permitted to remain in those settings while in CHC. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), Institute for Mental Disease or Hospital, unless it meets the standards for the heightened scrutiny process established under 42 C.F.R. § 441.301(c)(5) and is included in the PCSP. Instead, they must be located in residential neighborhoods in the community.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables PA Health & Wellness Participants to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24-hour staffing, by trained operators of the emergency response center, 365 days a year.

PERS services are limited to those individuals who: Live alone, are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances., live with an individual that may be limited in their ability to access a telephone quickly when a Participant has an emergency, or would otherwise require extensive in-person routine monitoring and assistance. Installation, repairs, monitoring and maintenance are included in this service.

Pest Eradication

Pest eradication services will be available to make a Participant's home fit for the Participant to live there. Pest Eradication Services are intended to aid in maintaining an environment free of insects, rodents, and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant's residence. The service may be considered for inclusion in the PCSP for a Participant transitioning to the community. It can also be made available on an ongoing basis, if necessary, as determined by the Service Coordinator (SC) and documented in the PCSP. That documentation needs to include the amount, duration and scope of services as determined by the SC. The service cannot be made available as a preference of the Participant to remove something on a property that has no impact on the Participant living there.

Residential Habilitation

Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in either Licensed or unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 Pa. Code Chapter 2600) or Assisted Living Residences (reference 55 Pa. Code Chapter 2800). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents.

Residential Habilitation services are provided for up to 24 hours a day. Residential Habilitation includes supports that assist Participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their PCSPs. This includes transportation to and from day habilitation and employment services.

Licensed settings may not exceed a licensed capacity of more than eight (8) unrelated individuals. Both licensed and unlicensed settings must be community-based and maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home, such as a kitchen and dining area. It provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants should have access to community activities, employment, schools or day programs.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), and Institute for Mental Disease or Hospital. Instead, they must be located in residential neighborhoods in the community.

Individual considerations may be available for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. By the nature of their behaviors, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced Staffing is treated as an add-on to the Residential Habilitation service and is only available when Participants require additional behavioral supports.

Residential Enhanced Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1
- Level 2: staff-to-individual ratio of 2:1 or greater

Respite

Respite services are provided to support individuals on a short-term basis due to the absence or

need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, the home of relative, friend, or other family, and are provided in quarter hour units. Respite may also be provided in a facility. Respite Services may be provided by a relative or family participant as long as the relative or family participant is not a legal guardian, power of attorney, or reside in the home.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the Participant and are directly related to a Participant's disability. These services or items are necessary to ensure health, welfare and safety of the Participant and enable the Participant to function in the home, community, or nursing facility with greater independence. This service is intended to enable Participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment.

Specialized Medical Equipment and Supplies includes Devices, controls or appliances, specified in the PCSP, that enable Participants to increase, maintain or improve their ability to perform activities of daily living, equipment repair and maintenance, unless covered by the manufacturer warranty, items that exceed the limits set for Medicaid State plan covered services, rental Equipment. In certain circumstances, needs for equipment or supplies may be time limited.

Non-Covered Items: All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream), items covered under third party payer liability, items that do not provide direct medical or remedial benefit to the Participant and/or are not directly related to a participant's disability, food, food supplements, food substitutes (including formulas), and thickening agents; eyeglasses, frames, and lenses; dentures, any item labeled as experimental that has been denied by Medicare and/or Medicaid, recreational or exercise equipment and adaptive devices for such. This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by an occupational therapist; a speech language pathologist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services offered through the waiver, Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate.

Hearing Aids require, but this service does not cover, an evaluation conducted by a physician certified by the American Board of Otolaryngology. Hearing aids must be purchased from and fitted by a licensed audiologist, licensed physician, or registered hearing aid fitter in association with a registered hearing aid dealer.

Specialized Medical Equipment and Supplies exclude Assistive Technology.

Structured Day Habilitation

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver Participants comprehensive day programming to acquire more independent functioning and improved

cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Services include social skills training, sensory/motor development, and education/elimination of maladaptive behavior. Services are directed at preparing the Participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Services must be separate from the Participant's private residence or other residential living arrangement. Providers may, however, provide Structured Day Habilitation Services in the community, a Participant's private residence or other residential living arrangement if the room used is used for the sole purpose of these services. The provider must operate the Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the Participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of Participants is not Medicaid reimbursable.

CHCs must consider enhanced staffing levels for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. These individuals, by the nature of their behaviors, are not able to participate in activities or are unable to access the community without direct staff support. Enhanced Structured Day Habilitation Services is an add-on to the Structured Day Habilitation Services and is only available when participants require additional behavioral supports.

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

Telecare

TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary to enable the Participant to promote independence and to ensure the health, welfare, and safety of the Participant and are provided pursuant to consumer choice.

TeleCare includes:

- Health Status Measuring and Monitoring TeleCare Service

- Activity and Sensor Monitoring TeleCare Service
- Medication Dispensing and Monitoring TeleCare Services

Health Status Measuring and Monitoring TeleCare Services: uses wireless technology or a phone line, including electronic communication between the Participant and healthcare Provider focused on collecting health related data (i.e. vital signs information such as pulse/ox and blood pressure that assists the healthcare Provider in assessing the Participant's condition) and providing education and consultation; must be ordered by a primary physician, physician assistant, or nurse practitioner; includes installation, daily rental, daily monitoring and training of the Participant, their representative and/or employees who have direct Participant contact; monitoring service activities must be provided by trained and qualified home health staff in accordance with required provider qualifications; and have a system in place for notification of emergency events to designated individuals or entities.

Activity and Sensor Monitoring TeleCare Service: employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively tracking Participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature; includes installation, monthly rental, monthly monitoring, and training of employees who have direct Participant contact; and ensures there is a system in place for notification of emergency events to designated individuals.

Medication Dispensing and Monitoring TeleCare Service: assists Participants by dispensing and monitoring medication compliance; and utilizes a remote monitoring system personally pre-programmed for each Participant to dispense, monitor compliance and provide notification to the provider or family caregiver of missed doses or non-compliance with medication therapy.

Therapeutic and Counseling Services

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Therapeutic and counseling services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the Participant in the implementation of the plan. This service may be delivered in the Participant's home or in the community as described in the service plan.

- Cognitive rehabilitation therapy services focus on the attainment/re-attainment of cognitive skills. The aim of therapy is the enhancement of the Participant's functional competence in real-world situations. The process includes the use of compensatory strategies and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing. Services are provided by an Occupational Therapist, licensed Psychologist, licensed Social Worker, licensed Professional Counselor, or a home health agency that employs them. Individuals with a bachelor's or master's degree in communication disorders, counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, or special

education who are not licensed or certified, may practice under the supervision of a practitioner who is licensed.

- Counseling services are non-medical counseling services provided to Participants in order to resolve individual or social conflicts and family issues. While counseling services may include family participants, the therapy must be on behalf of the Participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor. If there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan, through the Office of Mental Health and Substance Abuse Services, will cover the visit outside of the home and community-based services waiver up to pre-specified limits. Counseling services are utilized only once State Plan limitations have been reached, no diagnosis is present, or the service is deemed to not be Medically Necessary or not making meaningful progress under State Plan standards.
- Nutritional Consultation assists the Participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the Participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the Participant, caregiver and any Providers in the implementation of the plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the Participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of Participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Plans may exceed the 90-minute limit at their discretion and own cost. Home health agencies that employ licensed and registered dieticians may provide nutritional counseling. A provider of nutrition services should be a registered dietitian /nutritionist or a PA licensed dietitian / nutritionist.

- Behavior therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members, and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior therapy services are provided by a licensed psychologist, licensed social worker, licensed behavior specialist, or licensed professional counselor. A master's level clinician without licensure, certification or registration, must be supervised by a licensed Psychologist, licensed Social Worker, licensed Professional Counselor or licensed Behavior Analyst.

Vehicle Modifications

Vehicle modifications are modifications or alterations to an automobile or van that is the Participant's means of transportation in order to accommodate the special needs of the Participant. Vehicle modifications are modifications needed by the Participant, as specified in the service plan and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant and enable the Participant to integrate more fully into the community.

The following are specifically excluded: modifications or improvements to the vehicle that are of

general utility and are not of direct medical or remedial benefit to the Participant, purchase or lease of a vehicle with or without existing adaptations, regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications, the waiver cannot be used to purchase vehicles for Participants, their families or legal guardians.

Vehicle modifications funded through the waiver are limited to the following: vehicular lifts, portable ramps when the sole purpose of the ramp is for the Participant to access the vehicle, interior alterations to seats, head and leg rests and belts, customized devices necessary for the Participant to be transported safely in the community, including driver control devices, modifications needed to accommodate a Participant's special sensitivity to sound, light or other environmental conditions, raising the roof or lowering the floor to accommodate wheelchairs, the vehicle must be less than five (5) years old, and have less than 50,000 miles for vehicle modification requests over $3,000. All vehicle modifications shall meet applicable standards of manufacture, design and installation.

NETWORK DEVELOPMENT AND MAINTENANCE

PA Health & Wellness maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its participants, both adults and children, without excessive travel requirements, and that is in compliance with DHS's access and availability requirements.

PA Health & Wellness offers a network of primary care providers to ensure every participant has access to a Medical Home within the required travel distance standards.

In addition, PA Health & Wellness will have available, at a minimum, the following providers.

Specialists:

- Allergy and Immunology/Anesthesiology
- Cardiology
- Certified Mid Wife/CRNPs
- Dentist Anesthesiologist
- Dermatology
- Endocrinologist
- Gastroenterology
- General Surgery
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics & Gynecology
- Hematology/Oncology
- Ophthalmology
- Oral Surgery
- Orthopedic Surgery
- Otolaryngology
- Pharmacy
- Physical Medicine and Rehabilitation
- Podiatry
- Rheumatology
- Speech Therapy
- Urology

Facilities

- Acute Care Hospitals
- Common Laboratory and Diagnostic Services
- Skilled Nursing Facilities
- Rehabilitation Facilities
- FQHC/RHCs
- Opioid Use Disorder Centers of Excellence
- Adult Day Living

In the event PA Health & Wellness's network is unable to provide medically necessary services required under the contract, PA Health & Wellness shall ensure timely and adequate coverage of these services through an out of network Provider until a network Provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a PA Health & Wellness Participant, please contact our Medical Management team at 1-844-626-6813 and we will identify a Provider to make the necessary referral.

Non-Discrimination

We do not limit the participation of any Provider or facility in the network, and/or otherwise discriminate against any Provider or facility based solely on any characteristic protected under state or federal discriminate laws.

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on behalf of a Participant
- Filed a complaint against us
- Appealed a decision of ours

Tertiary Care

PA Health & Wellness offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available 24-hours per day in the geographical service area.

Out-of-Network

In the event PA Health & Wellness' network is unable to provide the necessary care services required, PA Health & Wellness shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

PA Health & Wellness will not impose any cost on the Participant for using an Out-of-Network Provider greater than those costs would have been if a Network Provider furnished the services.

PA Health & Wellness allows a Participant, who is an Indian as defined in 42 CFR § 438.14(a), to obtain Covered Services from Out-of-Network I/T/U HCPs (Indian Tribe, Tribal Organization, or Urban Indian Organization Health Care Providers) from which that Participant is otherwise eligible to receive services.

Network Termination

PA Health & Wellness must notify Network Providers in writing of their intent to terminate the Provider's contract a minimum of 180 days in advance of termination.

Refer to your Participating Provider Agreement (PPA) for additional information on termination from the network.

MEDICAL MANAGEMENT

Overview

PA Health & Wellness Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., EST (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about prior authorization.

Medical Management services include the areas of utilization management, care management, population health management, and quality review. The department clinical services are overseen by the PA Health & Wellness Chief Medical Officer. To reach the Chief Medical Officer contact Medical Management please contact: 1-844-626-6813

Medically Necessary

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

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

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in

writing. The determination is based on medical information provided by the Participant, the Participant's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Participant.

All such determinations must be made by qualified and trained health care providers.

Care Management Program

PA Health & Wellness care management model is designed to help your PA Health & Wellness participants obtain needed services, whether they are covered within the PA Health & Wellness array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help participants achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of eligible participants, needs assessment, and development and implementation person centered care plan that includes participant/family education and actively links the participant to providers and support services as well as outcome monitoring and reporting back to the PCP.

Needs Screening

Upon Enrollment, the PA Health & Wellness will conduct a needs screening using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Participant whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, and by mail.

Comprehensive Needs Assessment

The comprehensive needs assessment will be conducted by the Service Coordinator for each participant initially within 5 days of enrollment and reassessment at a minimum of every 12 months thereafter unless there is a change in condition or significant health event or requested by the participant/caregiver. This comprehensive needs assessment will be approved by the PA DHS and is used to help identify supports and services the participant may need. All support and services needs are reviewed and agreed upon by the participant and their identified caregiver/support. All documentation will be placed into our clinical documentation system which will support the development of the person-centered service plan (PCSP). All PCSPs will require agreement and signature by the participant or their designated representative as well as all providers that are part of the participant's PCSP (unless the participant requests to not share the PCSP with a provider(s)).

We will coordinate access to services not included in the core benefit package such as, dental, vision and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A Care Management (CM) team is available to help all providers manage their PA Health & Wellness participants. Listed below are programs and components of special services that are available and can be accessed through the care management team. We look forward to hearing from you about any PA Health & Wellness participants that you think can benefit from the addition of a PA Health & Wellness care management team participant.

- Link the participant to a Medical Home
- Educate participants about Self-Management of their condition
- Ensure Participant awareness of and compliance with medications
- Connect the participant to needed supports
- Transition of Care Program
- ED Diversion Program
- Whole-Person Care Management
- Discharge planning/coordination

To contact a care manager, call 1-844-626-6813.

Pregnancy Program

The Maternity Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant participants and providing care management to high and moderate risk participants through the postpartum period. A nurse care manager with obstetrical experience will serve as lead care manager for participants at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity team has physician oversight advising the team on overcoming obstacles, helping identify high risk participants, and recommending interventions. These physicians will provide input to PA Health & Wellness Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

PA Health & Wellness offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a participant is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the PA Health & Wellness care manager who will check for eligibility. The care manager will assist the participant with finding a pharmacy to fill the prescription as well as coordinate transportation to and from the physician's office. The nurse manager will contact the participant and do an assessment regarding compliance. The nurse will remain in contact with the participant and the prescribing physician during the entire treatment period. The Maternity Team works in collaboration with

local PCP's, FQHC's, Health Homes and local Health Departments to support this program with the goal of improved maternity/neonate care in Pennsylvania.

Contact the PA Health & Wellness care management department for enrollment in the obstetrical program.

Complex Care Unit Program

Our Care Managers in the Complex Care Unit (CCU) will provide outreach to participants identified with complex needs on the enrollment file and assist in locating Providers who meet the participant's personal circumstance. For participants at high risk or with complex needs, our integrated Community-Based CM Team provides a single point-of-contact ensuring that all the participant's needs are met, including selection of a PCP or Medical Home, if needed, appointment assistance, removal of barriers, etc. Providers play a key role in educating and engaging participants since they have existing relationships with participants and are often a trusted health information source.

These teams will be led by licensed registered nurses and/or licensed clinical social workers. Staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The CCU will manage care for participants whose need assistance managing their complex conditions such as HIV, diabetes, CHF, Hepatitis C traumatic brain injury, ventilator dependent and renal dialysis.

While the Care Manager will be the participant's main point of contact, which reduces confusion and promotes the participant-Care Manager relationship, the CM Team will collectively review and provide interdisciplinary input on the participant's needs and care. The BH clinician will serve as the liaison to the BH MCO, ensuring appropriate flow of clinical information and coordination of physical and behavioral health care and services if needed.

Our CCU staff will review complex needs indicators and other information provided on the enrollment file to identify new participants who may have a complex need. CCU staff, as well as pharmacy, participant services, and other participant-facing staff, will identify participants who may benefit from CCU services by ongoing review of information and from review of prior authorization requests or assessments of participant needs. We will use our data analytics capability as well as high-touch, face-to-face methods to identify participants with complex or chronic special need conditions, and we will leverage the system of care to ensure other entities serving our participants are aware of how to connect them to our CCU.

Our approach includes immediate participant (or parent/guardian, for minors) engagement, from initial assessment through planning and implementation of an individualized, holistic care plan. Engagement activities will include ensuring participants receive education and other supports they need to feel empowered to actively participate and self-advocate. Individualized for every participant, care plans will incorporate both covered and non-covered services to reflect the full range of health, behavioral health (BH), functional, social, and other needs. PA Health & Wellness will ensure Providers are aware of the participant's self-identified services and supports preferences and goals for their own care. The participant will be at the center of all care planning and monitoring activities, and with family/caregiver inclusion and supports, will drive the care they receive.

A CCU Coordinator will serve as a referral contact for the providers and other organizations serving our participants. Our CCU Coordinator can be reached by calling: 1-844-626-6813 or FAX the Care Management/Special Needs Unit Referral Form to 1-844-360-9981.

MemberConnections® Program

MemberConnections is PA Health & Wellness outreach program designed to provide education to our participants on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our care management program in order to link PA Health & Wellness and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of PA Health & Wellness within the community. The program has various components that can be provided depending on the need of the participant.

Participants can be referred to MemberConnections through numerous sources. Participants who call the PA Health & Wellness Customer Service department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify participants who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the MemberConnections Representative or their assigned care manager. Community groups may request that a MemberConnections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections

MemberConnections Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by PA Health & Wellness, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and PA Health & Wellness.

Home Connections

MemberConnections Representatives are available on a full-time basis whenever a need or request from a care manager, participant, or provider. All home visits are unscheduled due to the fact that the care manager has been unable to make contact with the participant. Some home visits can be scheduled when it involves them delivering a cell phone to the participant in order to have easier access to the participant. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections

MemberConnections Representatives may contact new participants or participants in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered, and any additional questions answered.

Connections Plus®

MemberConnections Representatives work together with the high-risk OB team or care management team for high-risk participants who do not have safe, reliable phone access. When a participant qualifies, a Connections Representative visits the participant's home and gives them a free, pre-programmed cell phone with limited use. Participants may use this cell phone to call the health plan care manager, PCP, specialty physician, 24/7 nurse advice hotline, 911, or other participants of their health care team.

Adopt a Schools Program

Participant Connection Representatives will actively promote healthy lifestyle activities related to disease prevention and health promotion by going into the schools of the communities served.

To contact the MemberConnections Team call 1-844-626-6813.

Chronic Care/Disease Management Programs

As a part of PA Health & Wellness services, Chronic Care Management Programs (CCMP) is offered to participants. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

PA Health & Wellness programs include but are not limited to asthma, diabetes and congestive heart failure. Our programs promote a coordinated, proactive, disease-specific approach to management that will improve participants' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Not all participants having the targeted diagnoses will be enrolled in the CCMP. Participants with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk participants with co-morbid or complex conditions will be referred for care management program evaluation. Chronic care management is considered an opt-out program such that all eligible members have the right to participate or to decline to participate.

To refer a participant for chronic care management:

- Call PA Health & Wellness Health Coaches at 1-844-626-6813
- Online: PAHealthWellness.com

Participants with Mental Health or Substance Misuse Needs

Behavioral health coverage is provided by Behavioral Health Managed Care Organizations (BH-MCOs) that contract with state or county Departments of Human Services. BH-MCOs are responsible for the utilization and clinical management of participants with mental health needs, substance misuse needs and/or dual diagnosis behavioral health needs (mental health and substance misuse diagnosis). To coordinate behavioral health services, refer the participant for behavioral health services or to seek an authorization for a behavioral health service, contact the assigned BH-MCO.

Care Coordination between PA Health and Wellness and BH-MCOs

PA Health & Wellness coordinates care with BH-MCOs using an integrated approach to address needs of participants with behavioral health needs and frequent co-morbid and co-occurring conditions which require an integrated approach to all aspects of care management and treatment. Care coordination incorporates interventions such as structured post-discharge telephone or in-person contacts; assessing satisfaction with outpatient providers; careful attention both to compliance with prescribed medications as well as potential impact of each medication on all PH and BH conditions.

County	BH-MCO	Participant Services Number
Adams	CCHBO	1-866-738-9849
Allegheny	CCBHO	1-800-553 7499
Armstrong	Beacon Health Options	1-877-688-5969
Beaver	Beacon Health Options	1-877-688-5970
Bedford	CCBHO	1-866-483-2908
Berks	CCBHO	1-866-292-7886
Blair	CCBHO	1-855-520-9715
Bradford	CCBHO	1-866-878-6046
Bucks	Magellan	1-877-769-9784
Butler	Beacon Health Options	1-877-688-5971
Cambria	Magellan	1-800-424-0485
Cameron	CCBHO	1-866-878-6046
Carbon	CCBHO	1-866-473-5862
Centre	CCBHO	1-866-878-6046
Chester	CCBHO	1-866-622-4228
Clarion	CCBHO	1-866-878-6046
Clearfield	CCBHO	1-866-878-6046
Clinton	CCBHO	1-855-520-9787

Columbia	CCBHO	1-866-878-6046
Crawford	Beacon Health Options	1-866-404-4561
Cumberland	PerformCARE	1-888-722-8646
Dauphin	PerformCARE	1-888-722-8646
Delaware	CCBHO	1-833-577-2682
Elk	CCBHO	1-866-878-6046
Erie	CCBHO	1-855-224-1777
Fayette	Beacon Health Options	1-877-688-5972
Forest	CCBHO	1-866-878-6046
Franklin	Performcare	1-866-773-7917
Fulton	Performcare	1-866-773-7917
Greene	CCBHO	1-866-878-6046
Huntingdon	CCBHO	1-866-878-6046
Indiana	Beacon Health Options	1-877-688-5969
Jefferson	CCBHO	1-866-878-6046
Juniata	CCBHO	1-866-878-6046
Lackawanna	CCBHO	1-866-668-4696
Lancaster	PerformCARE	1-888-722-8646
Lawrence	Beacon Health Options	1-877-688-5975
Lebanon	PerformCARE	1-888-722-8646
Lehigh	Magellan	1-866-238-2311
Luzerne	CCBHO	1-866-668-4696
Lycoming	CCBHO	1-855-520-9787
McKean	CCBHO	1-866-878-6046

Mercer	Beacon Health Options	1-866-404-4561
Mifflin	CCBHO	1-866-878-6046
Monroe	CCBHO	1-866-473-5862
Montgomery	Magellan	1-877-769-9782
Montour	CCBHO	1-866-878-6046
Northampton	Magellan	1-866-238-2312
Northumberland	CCBHO	1-866-878-6046
Perry	PerformCARE	1-888-722-8646
Philadelphia	Community Behavioral Health	1-888-545-2600
Pike	CCBHO	1-866-473-5862
Potter	CCBHO	1-866-878-6046
Schuylkill	CCBHO	1-866-878-6046
Snyder	CCBHO	1-866-878-6046
Somerset	CCBHO	1-866-483-2908
Sullivan	CCBHO	1-866-878-6046
Susquehanna	CCBHO	1-866-668-4696
Tioga	CCBHO	1-866-878-6046
Union	CCBHO	1-866-878-6046
Venango	Beacon Health Options	1-866-404-4561
Warren	CCBHO	1-866-878-6046
Washington	Beacon Health Options	1-877-688-5976
Wayne	CCBHO	1-866-878-6046
Westmoreland	Beacon Health Options	1-877-688-5977

Wyoming	CCBHO	1-866-668-4696
York	CCBHO	1-866-542-0299

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Provider is responsible for supervising, coordinating, and providing all authorized care to each assigned Participant. In addition, the Provider is responsible for ensuring the receipt of an authorization for all services from the Participant's case manager, maintaining continuity of each Participant's care and maintaining the Participant's medical record, which includes documentation of all services provided by the Provider as well as the Participant or responsible party's signature for receipt of covered services.

Role of the Service Coordinator

The Service Coordinator (SC) assists Participants to obtain LTSS services. The SC initiates the Person-Centered Service Plan (PCSP) process and oversees the implementation of the PCSPs and Care Planning. The SC will identify, coordinate and assist the Participant in gaining access to needed services: both covered and non-covered, medical, social, housing, educational and other services and supports. The Service Coordinator's Primary functions are to support the Participants and facilitate access to services. The SC is responsible for locating and coordinating services, Providers, Specialists, or other entities essential for care delivery. This will include seamless coordination between physical, behavioral, and support services.

Service Coordinators work with the Participant to identify strengths, goals, development of the PCSP, evaluations, reassessments, and establishing level of care. The SC will work with the Participant to complete activities necessary to maintain LTSS eligibility. The Service Coordinator will keep the Participant informed, while facilitating, locating, and monitoring needed services and support. Service alternatives and other options will be taken into consideration, such as Participant Directed Care, and other LTSS services. To contact a Service Coordinator, please call PA Health & Wellness at 1-844-626-6813.

Participants not requiring LTSS services but identified as requiring Care Planning and having unmet needs, services gaps, or a need for Care Management, are also identified and supported within the Service Coordination Care Management team.

Provider's Role in Service Planning and Service Coordination

The Provider is responsible supervising, coordinating, and providing authorized services. The Provider will also work with Service Coordinator(s) to address necessary services and supports and participate in the PCSP to ensure continuity of the Participants' needs. The Provider may participate in the Health Education Advisory Committee within the community to offer input on the health and education needs of Participants. The Provider will comply with the reporting requirements of the Participant Complaint, Grievance, and DHS Fair Hearing Processes. The Provider will support the Recipient Restriction program by working with the Service Coordinator, the MCO, and other pertinent Providers.

Service Request Process for LTSS Services

Long Term Services and Supports (LTSS) services require approval and authorization by PA Health & Wellness. Service request authorizations are sent to Providers by PA Health & Wellness once the Participant's comprehensive needs assessment is completed and the Participant's person-centered service plan is developed, reviewed, and agreed upon with the Participant and their identified caregivers/supports. Service requests will then be generated to appropriate service Providers.

Service Plans are reviewed with Participants during regularly scheduled face to face visits and assessments. If a Participant experiences a significant change in condition, if there is a change in level of support, or if the Participant requests, a change in service(s) or change in placement, there may be a resulting change to the Service Plan to better meet the Participant's needs.

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. PA Health & Wellness Providers are contractually prohibited from holding any PA Health & Wellness Participant financially liable for any service administratively denied by PA Health & Wellness. Continuity of care coverage begins on the Participant's effective date of enrollment for any existing services and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

Service Request Grievance Process

In the event a request for a service or item is denied, a Participant, Participant's representative, or healthcare Provider can file a grievance. A grievance is a request to have PA Health & Wellness reconsider a decision solely concerning the medical necessity and appropriateness of a requested LTSS service.

A Participant can file a grievance to dispute a decision to discontinue, reduce, or change a service or item within sixty (60) days from the date the Participant receives written notice of decision. The Participant must continue to receive the disputed service or item at the previously authorized level pending resolution of the grievance if the request for review is made orally, hand delivered, faxed, submitted via secure web portal, or post-marked within ten (10) days from the mail date on the written notice of decision.

The appeal process consists of a grievance review followed by the right to an external review and/or Fair Hearing process.

Emergency Care Services

PA Health & Wellness defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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:

1. 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
2. Impairments of bodily functions, or

3. Serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a)

Participants may access emergency services at any time without Prior Authorization or prior contact with PA Health & Wellness. Providers should inform Participants that if they are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Practitioner (PCP) and/or PA Health & Wellness' 24-hour Nurse Advice Hotline for assistance; however, this is not a requirement to access emergency services. PA Health & Wellness contracts with emergency services Providers as well as non-emergency Providers who can address the Participant's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by PA Health & Wellness when furnished by a qualified Provider, including out-of-network Providers, and will be covered until the Participant is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by PA Health & Wellness. Emergency services will cover and reimburse regardless of whether the Provider is in PA Health & Wellness' Provider network and will not deny payment for treatment obtained under either of the following circumstances:

1. A Participant had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the Plan instructs the participant to seek emergency services

Once the Participant's emergency medical condition is stabilized, PA Health & Wellness requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this manual.

UTILIZATION MANAGEMENT

The PA Health & Wellness Utilization Management Program (UMP) is designed to ensure Participants of PA Health & Wellness Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible Participants across all eligibility types, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of Provider and plan performance in providing access to care, the quality of care provided to Participants, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, home health, maternity care and ancillary care services.

PA Health & Wellness UMP seeks to optimize a Participant's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Development of quality standards for the region with the collaboration of the Provider Standards Committee.
- Monitoring utilization patterns to guard against over- or under- utilization

- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of care and/or population management for participants at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all PA Health & Wellness participants establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with Participants/Providers to enhance cooperation and support for UMP goals

Prior Authorizations

Failure to obtain the required approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. PA Health & Wellness providers are contractually prohibited from holding any PA Health & Wellness Participant financially liable for any service administratively denied by PA Health & Wellness for the failure of the Provider to obtain timely authorization. All out-of-network services require Prior Authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays.

This list is not all inclusive. Please visit PAHealthWellness.com and use the "Pre-Auth Check" tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral.

Services That Require Prior Authorization

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment (DME)
- Private Duty Nursing
- Adult Medical Day Care
- Home Health Care
- Hospice
- Furnished Medical Supplies and DME
- Orthotics/Prosthetics
- Genetic Testing
- Quantitative Urine Drug Screen
- Specialty Pharmaceuticals
- Out-of-Network Providers
- All Out-of-Network Providers require Prior Authorization (excluding emergency room services)

Procedures/Services

- Potentially cosmetic
- Bariatric surgery
- Transplants
- High tech imaging requests: RadMD.com
- High tech imaging administered by Evolent, i.e., CT, MRI, PET

- Obstetrical ultrasound
  Two (2) allowed in nine months.
  Prior authorization required for additional ultrasound(s), except if rendered by a Perinatologist
- Pain management
- Specific procedures identified in the “Pre-Auth Check” tool on the Provider Portal
- Services that are experimental/investigational

Inpatient Authorization

All elective/scheduled admission notifications requested at least five days prior to the scheduled date of admit including but not limited to:

- Medical admissions
- Surgical admissions
- All services performed in out-of-network facilities
- Rehabilitation facilities
- Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review
- Outpatient Programs

Procedures for Requesting a Prior-Authorization

The preferred method for submitting authorizations is through the Secure Provider Web Portal at Provider.PAHealthWellness.com. The Provider must be a registered user on the Secure Provider Web Portal. If the Provider is not already a registered user on the Secure Provider Web Portal and needs assistance or training on submitting Prior Authorizations, the Provider should contact his or her dedicated Provider Relations Representative. Other methods of submitting the Prior Authorization requests are as follows:

- **Call** the Medical Management Department at 1-844-626-6813. Please note: The Medical Management normal business hours are Monday – Friday 8am to 5pm. Voicemails left after hours will be responded to on the next business day.
- **Fax** prior authorization requests utilizing the Medicaid Prior Authorization fax forms posted on PAHealthWellness.com to 844-307-0997. *Please note faxes will not be monitored after hours and will be responded to on the next business day.*

Timeframes for Prior Authorization Requests and Notifications

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Any prior authorization request that is faxed or sent via the website after normal business hours (8:00 am – 5:00 pm, Monday – Friday, excluding holidays) will be processed the next business day.

Failure to obtain authorization may result in administrative claim denials.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 24 hours or by the next business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day, with delivery outcome

Authorization Determination Timelines

PA Health & Wellness decisions are made as expeditiously as the Participant's health condition requires.

Type	Timeframe
Preservice/Urgent	72 hours or 3 business days
Preservice/Non-Urgent	2 business days of of the receipt of request. An additional 14 calendar days if additional information is needed.
Concurrent review	1 business day, not to exceed 3 calendar days.

Clinical Information

PA Health & Wellness clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), PA Health & Wellness is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the Participant.

Information necessary for authorization of covered services may include but is not limited to:

- Participant's name, Participant ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to PA Health & Wellness within 2 business days or before discharge

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

PA Health & Wellness affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. PA Health & Wellness does not reward practitioners or other individuals for issuing denials of service or care. Financial incentives for Utilization Management (UM) decision makers do not encourage decisions that result in underutilization.

Delegated Providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any participant.

The treating physician, in conjunction with the Participant, is responsible for making all clinical decisions regarding the care and treatment of the Participant. The PCP, in consultation with the PA Health & Wellness Medical Director, is responsible for making utilization management (UM) decisions in accordance with the participant's plan of covered benefits and established PC criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Review Criteria

PA Health & Wellness has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the Participant's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 1-844-626-6813. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling PA Health & Wellness main toll-free phone number at 1-844-626-6813 and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Providers or Participants may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:
PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd
Mechanicsburg, PA 17050

Email: PHWComplaintsandGrievances@PAHealthWellness.com

Phone: 844-626-6813

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

Second Opinion

Participants or a healthcare professional, with the Participant's consent, may request and receive a second opinion from a qualified professional within the PA Health & Wellness network. If there is not an appropriate Provider to render the second opinion within the network, the participant may obtain the second opinion from an out-of-network provider at no cost to the Participant. Out-of-network and in-network Providers require prior authorization by PA Health & Wellness when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

PA Health & Wellness evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the PA Health & Wellness population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-844-626-6813.

Notification of Pregnancy

Participants that become pregnant while covered by PA Health & Wellness may remain a PA Health & Wellness Participant during their pregnancy. The managing physician should notify the PA Health & Wellness prenatal team by completing the Notification of Pregnancy (NOP) form (available at PAHealthWellness.com) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Concurrent Review Nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the Participant's attending physician. The Concurrent Review Nurse will review the Participant's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) business day of receipt of clinical information. For a length of stay extension request,

clinical information must be submitted by 3:00 p.m. EST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify PA Health & Wellness within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a Participant, but for which authorization and/or timely notification to PA Health & Wellness was not obtained due to extenuating circumstances (i.e. Participant was unconscious at presentation, Participant did not have their Medicaid ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined participant was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service. Presumptive eligibility rules apply. If the date of your retrospective review exceeds 90 calendar days from the date of service, follow the claims reconsideration process outlined in the Provider Billing Manual: https://www.pahealthwellness.com/providers/resources/forms-resources.html.

Speech Therapy and Rehabilitation Services

PA Health & Wellness offers our Participants access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to PA Health & Wellness as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our participants, PA Health & Wellness is using Evolent to provide prior authorization services and utilization. Evolent focuses on radiation awareness designed to assist Providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA

Key Provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has

been obtained. Failure to do so may result in claim non-payment

To reach Evolent and obtain authorization, please call 1-844-626-6813 and follow the prompt for radiology authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

PA Health & Wellness, in collaboration with Evolent, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient

Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed

Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for Participants, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography

- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-844-626-6813 and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

CLINICAL PRACTICE GUIDELINES

PA Health & Wellness clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, PA Health & Wellness adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

PA Health & Wellness providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program. Following is a sample of the clinical practice guidelines adopted by PA Health & Wellness:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by PA Health & Wellness, visit our website at PAHealthWellness.com. A paper copy of the practice guidelines can be requested by calling the Provider Relations department at 1-844-626-6813.

PHARMACY

PA Health & Wellness is committed to providing appropriate, high quality, and cost-effective outpatient medications as listed on the CMS Quarterly Drug Information File, when determined to be medically necessary to all PA Health & Wellness Participants. We work with Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are covered pharmacy benefits.

PA Health & Wellness covers prescription drugs and certain over the counter (OTC) drugs when ordered by a PA Health & Wellness prescriber at a $0-$3 copay. The pharmacy program covers medications that are Medicaid covered outpatient drugs. Certain medications may require prior authorization (PA) and/or have limitations on age, dosage and/or maximum quantities.

This section provides an overview of PA Health & Wellness pharmacy program. For more detailed information, please visit our website at PAHealthWellness.com.

Working with the Pharmacy Benefit Manager (PBM)

PA Health & Wellness works with Express Scripts to administer pharmacy benefits and with Pharmacy Services for the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by PA Health & Wellness.

These include:

- All medications designated as non-preferred on the Pennsylvania Medical Assistance Program's Statewide Preferred Drug List (PDL)
- Medications that do not appear on either the Statewide PDL or the health plan's supplemental drug list
- Some preferred drugs (designated as PA required on the state and supplemental Preferred Drug List)

Utilization Management (UM)

Both brand and generic drugs are listed within the PDL. Next to the medication in question, any associated utilization management abbreviations will be listed. Please reference the table below for additional UM abbreviation explanations.

Abbreviation	Term	Explanation
AL	Age Limit	Drug is only covered for certain ages
NP	Non-preferred	These drugs are non-preferred and may need to meet prior authorization before they will be covered
P	Preferred	Drug is preferred
QL	Quantity Limit	These drugs are only covered for a certain total amount
ST	Step Therapy	In some cases, you must first try certain drugs before PA Health & Wellness covers another drug for your medical condition

Pharmacy Prior Authorization

Drug Prior Authorization request for non-specialty drugs can be submitted to Pharmacy Services through phone, fax or online. To ensure timeliness of our Participants' pharmacy needs, PA Health & Wellness has a strict twenty-four (24) hour turnaround time requirement to process these requests.

Phone

- Prescribers may call Pharmacy Services to initiate a Prior Authorization or request a peer to peer by calling 1-866-399-0928.
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist Providers. NurseWise is available to assist Providers outside regular business hours.

- For claims related issues, the Pharmacy Help Desk can be reached by calling 1-833-750-4504 (Monday through Friday, 8:00 AM to 6:30 PM (EST)

FAX

- Prescribers may complete the PA Health & Wellness/ Centene Pharmacy Services Medication Prior Authorization Request form, found on the PA Health & Wellness website at PAHealthWellness.com
- Fax to Pharmacy Services at 1-844-205-3386. Once approved the prescriber is notified by fax
- If the clinical information provided does not explain the reason for the requested PA medication, response is sent to the prescriber by fax, offering PDL alternatives when available

Online Prior Authorization - Pharmacy

- CoverMyMeds is an online drug prior authorization (PA) program that allows prescribers to submit the PA process electronically. Prescribers locate the correct form, fill it out online, and then submit it to Pharmacy Services via fax. CoverMyMeds simplifies the PA submission process by automating drug prior authorizations for any medication. Additional chart notes may be required.
    - CoverMyMeds can be found at https://www.covermymeds.com/main/prior-authorization-forms/

For urgent or after-hours requests, the Pharmacy Services call center can be reached at 1-866-256-3483. The pharmacy can provide up to a 72-hour supply of medically necessary outpatient medications at point of sale using an override code. For Participants established on therapy and in need of a continuation Prior Authorization, the pharmacy can also provide up to a 15-day supply of the medication.

Pharmacy Claim Submission

For Pharmacy Services Pharmacy Paper Claim submissions, send correspondence to:

Attn: Pharmacy Services
Claim Submission
7625 N Palm Ave
Suite 107
Fresno, CA 93720

Pharmacy Claim Appeals

First Level Appeal: The right to appeal by a network pharmacy shall be limited to fourteen (14) calendar days following the initial claim. PBM shall investigate and resolve the appeal through an internal process within fourteen (14) calendar days of receipt of the appeal by the PBM. A Pharmacy may speak with an individual who is involved in the appeal process at (314) 848-5606. If PBM denies an appeal, PBM shall provide the reason for the denial and identify the national drug code of an equivalent drug that is available for purchase by the network pharmacy in this commonwealth from wholesalers at a price that is equal to or less than the NADAC cost for the appealed drug as determined by the PBM. If PBM grants and appeal, PBM shall make the price correction, permit the reporting pharmacy to reverse and rebill the appealed

claim and make the price correction effective for all similarly situated pharmacies from the date of the approved appeal. 40 P. S. §4533.

Second Level Appeal: After submitting a first level pricing appeal to PBM, if Provider has received a denial and wants to further dispute the outcome of the appeal, Provider may contact the PHW Clinical Pharmacy Services department by mail or secure email to:

PHW Clinical Pharmacy Services
1700 Bent Creek Blvd.
Suite 200
Mechanicsburg, PA 17050

PharmacyEscalationsPHW@PaHealthWellness.com

The following information must be submitted along with the Second Level Dispute:

- Evidence that the Pharmacy Provider has exhausted all of its remedies against the PBM (e.g. first level appeal outcome)
- Claim details, including:
  - Pharmacy National Council for Prescription Drug Programs (NCPDP) number
  - Pharmacy Name
  - Name of PSAO (if applicable)
  - Prescription number
  - National Drug Code (NDC)
  - Drug Name
  - Date of Fill
- Documentation of pricing information, as applicable:
  - From at least two wholesalers, inclusive of any additional rebates or discounts, showing that the wholesaler prices are not equal to or less than the NADAC price.
  - Desired pricing/reimbursement rate and reasoning for pricing change.
- Second Level Pricing Dispute can be denied if required information was not submitted by Pharmacy Provider.

Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes:

1. Second Level Pricing Disputes must be submitted to PHW within 15 business days of receiving a pricing appeal denial from the PBM.
2. PHW will respond to the Pharmacy Provider and the PBM with a final determination within 30 business days of receiving the Second Level Pricing Dispute from the Pharmacy Provider.

Preferred Drug List (PDL)

PA Health & Wellness utilizes a combination of the Pennsylvania Medical Assistance Program Statewide Preferred Drug List (PDL) as well as a supplemental drug list to determine drugs covered by

your prescription benefit. These lists are updated often and may change. You may view the Statewide PDL at https://papdl.com. To view the latest supplemental drug list, visit our website at www.PAHealthWellness.com or call us at 1-844-626-6813 (TTY/TDD: 711). Both the Statewide and the supplemental PDLs include all therapies available with and without PA in alignment with CMS covered outpatient medications. The PA list includes those drugs that require Prior Authorization for coverage. The PDLs apply to all medications a Participant may receive at network outpatient pharmacies. The supplemental PDL is continually evaluated by the PA Health & Wellness Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the PA Health & Wellness Medical Director, Pharmacy Director, and Pennsylvania physicians, pharmacists, and healthcare Providers.

Representation will also include physical health consumer as well as behavioral health consumer Participants.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the Provider or Pharmacist
- Relieve the Provider or Pharmacist of any obligation to the Participant or others

Both the Statewide PDL and the supplemental PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a “PA” notation throughout the PDL.

A paper copy of the current supplemental PDL can be requested by calling Provider Relations department at 1-844-626-6813.

Providers are requested to utilize the Statewide Preferred Drug List and supplemental drug list when prescribing medication to PA Health & Wellness Participants. If a pharmacist receives a prescription for a drug that requires a prior authorization request, the pharmacist should attempt to contact the provider to request a change to a product included in the Statewide or supplemental Preferred Drug List.

Pharmacy and Therapeutics Committee (P&T)

The PA Health & Wellness Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the supplemental PDL. The primary purpose of the Committee is to assist in developing and monitoring the PA Health & Wellness supplemental PDL in establishing programs and procedures that promote the appropriate and cost-effective use of medically necessary medications. The P&T Committee schedules meetings 4 times a year, the second Wednesday of the beginning of the quarter. All changes to the PDL are done in conjunction with the Commonwealth of Pennsylvania and revisions to PA Health & Wellness supplemental PDL that adversely impacts our Participants will be communicated at least 30 days in advance of those changes. Prior to implementation of changes, PA Health & Wellness submits all changes to the Commonwealth, based on the results of both the PA Health & Wellness P&T Committee and the requirements from the

Commonwealth of Pennsylvania. PA Health & Wellness will follow all State policies regarding participant notification when changes are made to prior authorizations.

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine. Reimbursement decisions for specific non-approved indications will be made by PA Health & Wellness. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

Both the Pennsylvania Medical Assistance Program Statewide Preferred Drug List (PDL) as well as a supplemental drug list include a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the preferred medications included in both PDLs for their patients who are Participants of PA Health & Wellness. Some drugs will require PA (Prior Authorization) and are listed on the PA list. In addition, all name brand drugs not listed on either the PDL or PA list will require prior authorization. If a request for Prior Authorization is needed the information should be submitted by the physician/clinician to Pharmacy Services on the PA Health & Wellness form: Medication Prior Authorization Request Form. This form should be faxed to Pharmacy Services at 1-844-205-3386. This document is located on the PA Health & Wellness website at PAHealthWellness.com. PA Health & Wellness will cover the medication if it is determined that:

- There is a medical reason the Participant needs the specific medication.
- Depending on the medication, other medications on the PDL have not worked.

Prior Authorization requests for specialty medications should be faxed to Pharmacy Services at 1-844-205-3386.

All reviews are performed using the criteria established by Pennsylvania's Department of Medical Assistance Pharmacy Department or the PA Health & Wellness P&T Committee. If an adverse medical determination is recommended by the clinical pharmacist, a Pennsylvania licensed physician will make the decision to deny this PA request. Only a licensed physician can issue a medical denial determination. Once approved,the prescriber/clinician will be notified by fax. If the clinical information provided does not meet the medical necessity and or prior authorization guidelines for the requested medication, PA Health & Wellness will notify the Participant and the prescriber and provide information for the appeal process.

The PHW P&T committee has reviewed and approved, with input from its Participants and in consideration of medical evidence, the list of drugs requiring Prior Authorization within the supplemental PDL. This PDL attempts to provide appropriate and cost-effective drug therapy to all Participants covered under the PA Health & Wellness pharmacy program. If a patient requires a brand name medication that does not appear on the PDL, the physician/clinician can make a PA request for the brand name medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. A phone or fax-in process is available for PA requests.

Pharmacy Solutions Contact Information:

Prior Authorization FAX: 1-844-205-3386

Prior Authorization Phone: 1-866-399-0928

Mailing Address: 5 River Park Place East,
Suite 210, Fresno, CA 93720

72 Hour Emergency Supply of Medications

Commonwealth and federal law require that a pharmacy dispense a minimum of a 72-hours supply. PA Health & Wellness will allow a 72-hour supply of medication to any patient awaiting a prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied. This is in addition to those Participants on chronic medications who qualify for a 15-day supply. The pharmacy will submit override codes provided in point of sale (POS) messaging.

Newly Approved Products

We review new drugs for safety and effectiveness before adding them to the supplemental PA Health & Wellness PDL. During this period, access to these medications will be granted to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the PDL, or through prior authorization, within 10 days from their availability in the marketplace.

Step Therapy

Some medications listed on the PA Health & Wellness PDL may require specific medications to be used before you can receive the step therapy medication. If PA Health & Wellness does not have a record that the required medication was tried, the Participant or physician/clinician may be required to provide additional information. If PA Health & Wellness does not grant PA, we will notify the Participant and physician/clinician and provide information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the PA Health & Wellness PDL and are not covered by the 72-hour emergency supply policy:

- Fertility enhancing drugs
- Anorexia, or weight gain drugs
- Immunizations are medical benefits that do not require Prior Authorization. The exception to this is the influenza vaccine which has no PA approval requirements and is available as a pharmacy benefit to all of our Participants.
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Exclusions as specified by the Commonwealth

Injectable Drugs

Injections as defined by CMS list of covered outpatient drugs as listed on the CMS Quarterly Drug Information File when determined to be medically necessary are approved pharmacy benefits to our PA Health & Wellness Participants.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 31-day supply for each new or refill non-controlled substance. A total of 80 percent (80%) of the days supplied for a non-controlled medication must have elapsed before the prescription can be refilled without a Prior Authorization approval. A prescription can be filled after 26 days. Dispensing outside the quantity limit (QL) or age limits (AL) requires Prior Authorization. PA Health & Wellness may limit how much of a medication a Participant can get at one time. If the physician/clinician feels a Participant has a medical reason for getting a larger amount, he or she can ask for Prior Authorization. If PA Health & Wellness does not grant a Prior Authorization approval, we will notify the Participant and physician/clinician and provide information regarding the appeal process. Some medications on both the Statewide and supplemental PDLs may have age limits. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns as well as current medically accepted quality standards of care as supported by clinical literature. The age limits align with current FDA and medical standards of care for the appropriate use of pharmaceuticals in improving outcomes for our Participants. There is always consideration of the exception process for medically necessary treatments.

Mandatory Generic Substitution

Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the Participant or physician/clinician feels a brand name drug is medically necessary, the

physician/clinician can ask for an authorization. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the Participant needs the particular brand name drug. If PA Health & Wellness does not grant authorization, we will notify the Participant and physician/clinician and provide information regarding the appeal process. Medication therapeutic substitutions, or the process of filing of a medication prescription with a different medication in the same pharmacologic class, will not be conducted at a retail setting without consultation with the prescriber.

Over-The-Counter Medications (OTC)

The pharmacy program covers DHS approved OTC medications. All OTC medications must be written on a valid prescription by a licensed physician in order to be reimbursed.

Prior Authorization by Phone

When calling, please have Participant information, including Medicaid ID number, Participant date of birth, complete diagnosis, medication history, and current medications readily available. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific Participants to receive this specific drug.

If the request is denied, information about the denial will be provided to the Provider and the Participant.

In the event that a Provider or Participant disagrees with the decision regarding coverage of a medication, the Participant or the Provider, on the Participant's behalf, may submit an appeal, verbally or in writing. For additional information about appeals, please refer to the Appeals section herein.

Recipient Restriction Program

PA Health & Wellness maintains a Participant Restriction (Lock-in) Program to interface with the Department's Recipient Lock-in Program and will provide for appropriate professional resources to manage the program and to cooperate with the Department in all procedures necessary to restrict Participants. In accordance with 42 CFR § 431.54(e), the restrictions do not apply to emergency services furnished to the Participant.

The process includes:

- Identifying Participants who are over-utilizing or mis-utilizing medical services, receiving unnecessary services or may be defrauding the MA program.
- Offering a voluntary restriction to a participant to protect his/her medical card from alleged misuse. A voluntary restriction can end at any time.
- Evaluating the degree of abuse including review of pharmacy, medical, and inpatient claims/encounter history, diagnoses and other documentation, as applicable.
- Proposing whether the Participant should be restricted to obtaining services from a single, designated Provider for a period of five (5) years.
- Forwarding case information and supporting documentation to the Bureau of Program Integrity (BPI) at the address below or via secure electronic method for review to determine appropriateness of restriction and to approve the action.
- Forwarding case information to BPI for allegations of participant fraud.

- Upon BPI approval, sending notification via certified mail to the Participant of the proposed Lock-in, including reason, effective date and length of Lock-in, name of designated Provider(s) and option to change Provider(s) and appeal rights, with a copy to BPI.
- Sending notification of the Participant's Lock-in to the designated Provider(s) and the CAO.
- Enforcing Restrictions (Lock-ins) through appropriate notifications and edits in the claims payment system.
- Preparing and presenting case at a DHS Fair Hearing to support Lock-in action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Participant, Department, or Provider's request, within thirty (30) days from the date of the request, with prompt notification within 5 business days to BPI through the Intranet Provider change process.
- Continuing a Participant Lock-in from the previous delivery system as a Participant enrolls in an MCO, with written notification to BPI.
- Reviewing the Participant's services prior to the end of the Lock-in period to determine if the Lock-in should be removed or maintained, with notification of the results of the review to BPI, Participant, Provider(s) and CAO.
- Performing necessary administrative activities to maintain accurate records.
- Educating Participants and Providers about the Lock-in program, including explanations in handbooks and printed materials.

MA Participants may appeal a Lock-in by requesting a DHS Fair Hearing but may not file a Complaint or Grievance with PA Health & Wellness. A request for a DHS Fair Hearing must be in writing, signed by the Participant and sent to:

Department of Human Services Office of Administration
Bureau of Program Integrity
Division of Program and Provider Compliance Recipient Restriction
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone number: (717) 772-4627

Note: A recipient placed in this program can be locked-in to any number of Providers at one time. Restrictions are removed after a period of five years if improvement in use of services is demonstrated.

If a recipient is restricted to a Provider within a Provider type, the EVS will notify a Provider if the recipient is locked into a Provider. The EVS will also indicate all type(s) of Provider(s) to which the recipient is restricted.

Note: Valid emergency services are excluded from the lock-in process.

PROVIDER RELATIONS AND SERVICES

Provider Relations

PA Health & Wellness' Provider Relations department is committed to supporting Providers as they care for our Participants. Through New Provider Orientations, ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each Provider will be assigned a Provider Network Specialist. Provider Relations will contact newly contracted Providers to schedule an orientation, which must be completed within 30 days of the contract

being executed. To reach our Provider Relations team, please email PHWProviderRelations@PAHealthWellness.com.

Reasons to Contact a Provider Relations Representative

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Request fee schedule information
- Obtain Participant roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and Participant eligibility
- Open/close patient panel

Provider Services

Provider Services is available at 1-844-626-6813 Monday through Friday 8am to 5pm and closed on State holidays.

CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that PA Health & Wellness maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our Providers. This includes verifying licensure, board certification, and education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base. Participating providers must meet the criteria established by PA Health & Wellness, as well as government regulations and standards of accrediting bodies.

PA Health & Wellness requires re-credentialing at a minimum of every 3 years because it is essential that we maintain current Provider professional information. This information is also critical for PA Health & Wellness' Participants, who depend on the accuracy of the information in its Provider directory.

Note: In order to maintain a current Provider profile, Providers are required to notify PA Health & Wellness of any relevant changes to their credentialing information in a timely manner.

Which Providers Must be Credentialed?

The following Providers are required to be credentialed:

Medical practitioners

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners
- Other medical practitioners

Behavioral healthcare practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral healthcare specialists

Information Provided at Credentialing

All new practitioners and those adding practitioners to their current practice must submit at a **minimum** the following information when applying for participation with PA Health & Wellness:

- A completed, signed and dated Credentialing application
- Providers can authorize PA Health & Wellness access to their information on file with the CAQH (Council for Affordable Quality Health Care) www.CAQH.org
- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with Pennsylvania regulations regarding malpractice coverage or alternate coverage
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 90 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Disclosure of Ownership & Controlling Interest Statement

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- A completed, signed and dated Pennsylvania Standardized Credentialing application

If applying as an ancillary or clinic Provider, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO)
  - If not accredited by a nationally recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
- Copy of W-9

If applying as a hospital, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Hospital/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO)
  - If not accredited by a nationally recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Copy of W-9

Once PA Health & Wellness has received an application, it verifies the following information, at a minimum, submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current participation in the Pennsylvania Medicaid Program
- A current Pennsylvania license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements

- Five-year work history
- Social Security Death Master File
- Federal and state sanctions and exclusions including the following sources:
    a. Office of Inspector General (OIG)
    b. The System for Award Management (SAM)
    c. PA Medicheck
    d. Medicare Opt-Out Listing

Once the application is complete, the PA Health & Wellness Credentialing Committee (Credentialing Committee) renders a final decision on acceptance following its next regularly scheduled meeting.

Per Pennsylvania Medical Assistance bulletin 99-11-05 effective 8/15/15, providers who participate in the Medical Assistance Program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid, and any other federal health care program. These sources include at a minimum OIG, SAM and PA Medichek.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for Provider participation. It is also responsible for termination and direction of the credentialing procedures, including Provider participation, denial and termination.

Committee meetings are held at least monthly and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing

To comply with accreditation standards, PA Health & Wellness re-credentials Providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the Provider is under contract to provide. This process includes all Providers, primary care Providers, Specialists and ancillary Providers/facilities previously credentialed to practice within the PA Health & Wellness network.

In between credentialing cycles, PA Health & Wellness conducts ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, PA Health & Wellness reviews monthly reports including OIG, SAM, Medicare Opt Out and PA Medicheck to identify network Providers who have been newly sanctioned or excluded from participation in federal and state programs.

Loss of Network Participation

A Provider's agreement may be terminated at any time if PA Health & Wellness' Credentialing Committee determines that the Provider no longer meets the credentialing requirements.

Upon notification from the Department that a Provider with whom PA Health & Wellness has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, PA Health & Wellness will immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All Providers participating within the PA Health & Wellness network have the right to review information obtained by the Health Plan that is used to evaluate Providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a Provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a Provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the Provider, the Provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to PA Health & Wellness' Credentialing Department. Upon receipt of this information, the provider has 14 days to provide a written explanation detailing the error or the difference in information. The PA Health & Wellness Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All Providers who have submitted an application to join PA Health & Wellness have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Network Specialist at 1-844-626-6813.

Right to Appeal Adverse Credentialing Determinations

PA Health & Wellness may decline an existing Provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the Provider has the right to request reconsideration in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the PA Health & Wellness network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. PA Health & Wellness will send a written response to the Provider's reconsideration request within two weeks of the final decision.

Disclosure of Ownership and Control Interest Statement

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require Providers (other than an individual practitioner or group of practitioners) who are entering into or renewing a Provider agreement to disclose:

- The identity of all owners with a control interest of *5%* or greater
- Certain business transactions as described in 42 CFR 455.105
- The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity

PA Health & Wellness furnishes Providers with the Disclosure of Ownership and Control Interest Statement as part of the initial contracting process. This form should be completed and returned along with the signed Provider agreement. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to PA Health & Wellness within 30 days of the change. Please contact PA Health & Wellness Provider Relations Department at 1-844-626-6813 if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

PROVIDER EDUCATION

Overview

Provider Education is offered throughout the year. All online education can be found on our website at PAHealthWellness.com (**Provider Training**). It is our goal at PA Health & Wellness to develop and maintain a Provider Network that is knowledgeable and experienced in treating and supporting Participants in Community HealthChoices. PA Health & Wellness includes feedback gathered from Providers, Participants, advocates, direct care worker representatives, and family members in design and implementation of the annual provider education offered. If you have any feedback on the training or have suggestions on how it can be improved, please email us at ProviderTraining@PAHealthWellness.com or call us at 1-844-626-6813.

Provider Education: Training Offered

PA Health & Wellness offers trainings throughout the year that include a wide variety of material. We include training on the following topics, in addition to special topic trainings each month:

a. Needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the Provider's role in service planning and Service Coordination.

b. Service Coordination and how the Provider will fit into the Person-Centered Planning Team (PCPT) approach. The PCPT is a team of individuals that participates in Person-Centered Service Planning with and provides person-centered coordinated services to a Participant.

c. The population being served through Community HealthChoices.

d. Accessibility requirements with which Providers must comply.

e. Application of the definition of Medically Necessary: Compensable under the MA Program and meeting any one of the following standards:

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

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

- Definition of dementia
- Early warning signs
- Identifying symptoms
- Interventions & treating symptoms

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

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

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

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

k. Treating the populations served by PA Health & Wellness, including treatment for Participants with disabilities.

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

m. Issues identified by Provider Relations or Provider Services staff in response to calls or complaints by Providers.

n. Issues identified through the Quality Management (QM) process.

o. The process to submit materials to PA Health & Wellness for utilization review and Prior Authorization review decisions. Submitted materials must include, but are not limited to, letters of medical necessity.

p. The Complaint, Grievance and DHS Fair Hearing and Appeals process, including, but not limited to, expectations for a Provider should a Provider represent a Participant at a Grievance hearing.

q. Performance Improvement Projects (PIP) and how Providers may benefit from participation in these programs.

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

s. Medical Assistance Provider self-review protocol.

Annual Training Requirement: Home & Community-Based Service (HCBS) Providers Only

This is an annual training requirement for all Home and Community Based Services (HCBS) Providers contracted with PHW's Community HealthChoices (CHC) Plan. At least one person from each organization (Tax ID#) must complete this training annually. For more information or to access this training, visit PAHealthWellness.com – Provider Training.

HCBS Provider Types required to complete this training include:

- Adult Daily Living
- Assistive Technology
- Behavior Therapy Services
- Benefits Counseling
- Career Assessment
- Cognitive Rehabilitation Therapy Services
- Community Integration
- Community Transition Services
- Counseling Services
- Employment Skills Development
- Financial Management Services
- Home Adaptations
- Home Delivered Meals
- Home Health Aid Services
- Job Coaching
- Job Finding
- Non-Medical Transportation
- Nursing Services
- Nutritional Consultation Services
- Occupational Therapy

- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Pest Eradication
- Physical Therapy
- Residential Habilitation
- Respite
- Specialized Medical Equipment and Supplies
- Speech and Language Therapy
- Structured Day Habilitation
- Telecare
- Vehicle Modifications

RIGHTS AND RESPONSIBILITIES

Participant Rights

Participants have certain rights. PA Health & Wellness expects Providers to respect and honor Participants' rights.

A participant has the right to:

• Receive information in a manner and format that may be easily understood and is readily accessible to Participants and potential Participants.

• Receive accurate, easily understood information and assistance in making informed health care and LTSS decisions about his or her health plans, professionals, and facilities.

• A choice of healthcare and LTSS providers that is sufficient to ensure access to appropriate high-quality healthcare.

• Access emergency health care services when and where the need arises.

• Fully participate in all decisions related to his or her healthcare and LTSS. Participants who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

• Considerate, courteous and respectful care from all members of the healthcare and LTSS system at all times and under all circumstances.

• Communicate with Providers in confidence and to have the confidentiality of his or her individually identifiable healthcare and LTSS information protected. Participants also have the right to review and copy his or her own medical and LTSS records and request amendments or corrections to their records.

• A fair and efficient process for resolving differences with their health plans, healthcare and LTSS Providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

Participant Responsibilities

Participants have the responsibility to:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with healthcare and LTSS Providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a healthcare and LTSS Provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan and LTSS coverage and health plan and LTSS options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients, health workers, and LTSS workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, healthcare and LTSS Providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

Provider Rights

PA Health & Wellness Providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for Participants' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in Participants' treatment plans
- Expect Participants to follow their directions
- Make a complaint or file an appeal against PA Health & Wellness and/or a Participant
- File a grievance with PA Health & Wellness on behalf of a Participant, with the Participant's consent
- Have access to information about PA Health & Wellness Quality Improvement programs, including program goals, processes, and outcomes that relate to participant care and services
- Contact PA Health & Wellness Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of Participants
- Not be prohibited or restricted, if acting within the lawful scope of practice, from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Participant, including information regarding the nature of treatment options in order to decide among those options; the risks, benefits, and consequences of treatment and non-treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.
- Not be prohibited or restricted, if an LTSS Provider acting within the lawful scope of practice, from discussing needed services and advising or advocating appropriate LTSS with or on behalf of a Participant, including information regarding the nature of LTSS options; risks; and the availability of alternative services.

Provider Responsibilities

PA Health & Wellness providers have the **responsibility** to:

- Help Participants or advocate for Participants to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered

- Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options

- Treat Participants with fairness, dignity, and respect
- Not discriminate against Participants on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of participants' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give Participants a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider's practice/office/facility
- Provide Participants with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow Participants to request restriction on the use and disclosure of their personal health information
- Provide Participants, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to Participants, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the participant to participate in the decision-making process
- Tell a Participant if the proposed medical care or treatment is part of a research experiment and give the Participant the right to refuse experimental treatment
- Allow a Participant who refuses or requests to stop treatment the right to do so, as long as the participant understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect Participants' Advance Directives and include these documents in the Participants' medical record
- Allow Participants to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow Participants to obtain a second opinion, and answer Participants' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in PA Health & Wellness data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by PA Health & Wellness
- Comply with PA Health & Wellness Medical Management program as outlined in this handbook

- Disclose overpayments or improper payments to PA Health & Wellness
- Provide Participants, upon request, with information regarding the Provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to PA Health & Wellness information regarding other insurance coverage
- Notify PA Health & Wellness in writing if the provider is leaving or closing a practice
- Contact PA Health & Wellness to verify Participant eligibility or coverage for services, if appropriate
- Invite Participant participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide Participants, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Office hours of operation offered to Medicaid Participants will be no less than those offered to commercial Participants
- Not be excluded, penalized, or terminated from participating with PA Health & Wellness for having developed or accumulated a substantial number of patients in the PA Health & Wellness with high-cost medical conditions
- Coordinate and cooperate with other service providers who serve Medicaid Participants, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school-based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to PA Health & Wellness, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between PA Health & Wellness and the physician or physician group
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement
- Allow PA Health & Wellness direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs
- Review and follow clinical practice guidelines distributed by PA Health & Wellness
    - Document Medical chart with up to three reach out attempts via phone to Participants who have not completed an office visit in the past 12 month or more
    - Have been discharged from an inpatient-stay within the last 24 hours since notification

- Have a gap-in-care overdue by 30 or more days

- Develop report based on PA Health & Wellness specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one year of enrolling in the PA Health & Wellness Provider Network
- Comply with Pennsylvania Risk Adjustment programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines
- Report all suspected physical and/or sexual abuse and neglect
- Report Communicable Disease to PA Health & Wellness:
  - PA Health & Wellness must work with DOH State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately report reportable conditions in accordance with 28 Pa. Code §§ 27.1 et seq.
- Providers in the PA Health & Wellness Network may not bill Participants for medically necessary services that PA Health & Wellness covers, this is called balance billing.

It is your responsibility as a Provider to participate in education on proper reporting of communicable disease and reportable conditions. PA Health & Wellness has designated a single point of contact for reportable conditions, who can be reached by calling 1-717-809-7035 or 1-866-535-2545 or by faxing to 1-844-873-7451. A copy of this policy can be found on our website, PAHealthWellness.com.

PA Health & Wellness Providers shall not engage in solicitation of Participants to receive services from the Provider including:

- Referring an individual for CHC evaluation with the expectation that, should CHC enrollment occur, the Provider will be selected by the Participant as the service provider
- Communicating with existing CHC Participants via telephone, face-to-face or written communication for the purpose of petitioning the Participant to change Providers
- Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHC Participants

PARTICIPANT COMPLAINT AND GRIEVANCE PROCESS

A Participant, Participant's representative or a Participant's Provider (with written consent from the Participant), may file a Participant Complaint or Grievance either verbally or in writing. *These processes exclude Provider claims disputes or claims inquiries.*

PA Health & Wellness provides Participants assistance in completing all forms and taking other steps of the Complaint and Grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD.

PA Health & Wellness values its Providers and will not take punitive action, including termination of a Provider agreement or other contractual arrangements, for Providers who file a Complaint or Grievance on a Participant's behalf. PA Health & Wellness aids both Participants and Providers with filing a

Complaint or Grievance by contacting our Participant and Provider Services Department at 1-844-626-6813.

Participant Complaints

A Participant Complaint is defined as a dispute or objection regarding a Provider or the coverage, operations, or management policies of PA Health & Wellness, which has not been resolved by PA Health & Wellness and has been filed with PA Health & Wellness or with DOH or PID, including but not limited to:

- a denial because the requested service or item is not a Covered Service, which does not include BLE;
- the failure of PA Health & Wellness to meet the required time frame for providing a service or item;
- the failure of PA Health & Wellness to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by PA Health & Wellness after a service or item has been delivered because the service or item was provided without authorization or by a provider not enrolled in the MA Program;
- a denial of payment by PA Health & Wellness after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a Grievance.

The Participant must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of a decision. A Participant Complaint is subject to resolution by PA Health & Wellness within thirty (30) days of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant. PA Health & Wellness has a two-level Complaint process.

Acknowledgement

If PA Health & Wellness staff receive Complaints through the Plan's Customer Service Call Center, the complaints are documented, and an attempt is made to resolve immediately. Staff document the substance of the Complaint, any actions taken to resolve the issue and any requested actions made by the Participant. All Complaints are forwarded to the Complaint and Grievance Unit for final follow-up and resolution. Written complaints are time and date stamped upon receipt and an acknowledgment letter, which includes a description of the complaint, procedures and resolution time frames is sent within three (3) business days of receipt.

First Level Complaint Review

PA Health & Wellness permits a Participant, the Participant's representative or the Participant's Provider (with written permission of the Participant) to file a written or oral Complaint. The Participant, the Participant's representative or the Participant's Provider may review information related to the Complaint

upon request and submit additional material to be considered by PA Health & Wellness. The Participant and/or the Participant's representative may attend the first level Complaint review in person, via telephone or videoconference. The Participant may elect not to attend the first level Complaint review meeting, but the meeting will be conducted with the same protocols as if the Participant was present.

The first level Complaint review is performed by a first level Complaint review committee, which includes one or more employees of PA Health & Wellness. Any individuals who make a decision on Complaints will not be involved in any previous level of review or decision making regarding the subject of the Complaint. In any case, where the reason for the complaint involves clinical issues or relates to denial of expedited resolution of a grievance, PA Health & Wellness ensures that the decision makers are health care professionals with the appropriate clinical expertise in treating the Participant's condition or disease.

The Participant will receive written notice of the first level Complaint committee's decision within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant. The notification will include the Compliant resolution as well as instructions on how to file a second level Complaint review, external review, or Fair Hearing, whichever is applicable.

If the Complaint disputes one of the following, the Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

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

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

The Participant, Participant's representative, or the Participant's Provider (with written permission of the Participant) may file a request for an external review in writing with PID's BMC within fifteen (15) days from the date the Participant receives written notice of the first level Complaint decision.

For all other Complaints, the Participant, Participant's representative, or the Participant's Provider (with written permission of the Participant) may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Participant receives written notice of the first level Complaint decision.

Second Level Complaint Review

Upon receipt of the request for a second level Complaint review, PA Health & Wellness sends the Participant, and when applicable, the Participant's representative an acknowledgement letter confirming the second level Complaint within three (3) business days of receipt of the request. The Participant and/or Participant's representative may attend the second level review in person, via telephone or video conference. PA Health & Wellness notifies the Participant and/or Participant's representative at least fifteen (15) days prior to the date of the second level Complaint review meeting.

The second level Complaint review is performed by a second level review committee made up of three (3) or more individuals who did not participate in the matter under review. At least one third of the second level review committee will be a representative of the community and not an employee of PA Health & Wellness or any affiliate.

The second level review committee issues a formal decision within forty-five (45) days of the receipt of the request for a second level Complaint review. PA Health & Wellness sends a written notice of the decision to the Participant and/or Participant's representative.

If the Participant is dissatisfied with the second level review committee decision, the Participant, Participant's representative, or Participant's Provider may file in writing a request for an external review of the second level Complaint decision with PID's BMC within fifteen (15) days from the date the Participant receives the written notice of the second level Complaint decision.

Notice of Resolution

The Complaint and Grievance Unit provides written resolution to the Participant, the Participant's representative or Participant's Provider within the timeframes noted above. The Complaint response includes, but is not limited to, a statement of the issue reviewed by the Committee, the decision reached by PA Health & Wellness, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Participant, if any. Logs and records of disposition or written complaints are retained for ten years.

Complaints may be submitted by written notification to:

PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd
Mechanicsburg, PA 17050

Participant Grievances

A Participant, Participant's representative, or Participant's Provider (with written permission from the Participant) must file a grievance within sixty (60) days from the date the Participant receives written notice of decision. Grievances may be filed either orally or in writing via mail, by fax, via secure web portal, or by email.

A Participant Grievance is a request to an MA Managed Care Plan by a Participant or a health care provider (with the written consent of the Participant), or a Participant's authorized representative to have an MA Managed Care Plan reconsider a decision solely concerning the medical necessity,

appropriateness, health care setting, level of care or effectiveness of a health care service. If the MA Managed Care Plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

- disapproves full or partial payment for a requested healthcare service;
- approves the provision of a requested health care service for a lesser scope or duration than requested;
- disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service;
- reduces, suspends, or terminates a previously authorized service.

This term does not include a Complaint

A Participant who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, faxed, submitted via secure web portal, or post-marked within fifteen (15) days from the mail date on the written notice of decision.

Acknowledgement

Grievances received orally through the Plan's Customer Service Call Center are date and time stamped in the Call Center system. Written Grievances are date and time stamped upon initial receipt. Upon receipt of a valid grievance, an acknowledgment letter is sent within three (3) business days, which includes a description of the Grievance, procedures, and resolution time frames.

Grievance Review

PA Health & Wellness must give the Participant at least ten (10) days advance written notice of the Grievance review date. The Participant, Participant's representative, or Participant's Provider who filed the grievance may attend the Grievance review in person, via telephone or video conference. The Participant may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All Grievance review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Grievance record.

The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. The Grievance review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician must decide the Grievance.

Participant Grievance Resolution Time Frame

Grievance resolution occurs as expeditiously as the Participant's health condition requires, not to exceed thirty (30) calendar days from the date of the initial receipt of the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant.

Notice of Resolution

A copy of all grievances logs, and records of disposition or written grievances are retained for ten years. PA Health & Wellness notifies the Participant, the Participant's representative, or Participant's Provider, if the provider filed a Grievance, with Participant consent, of the Grievance review committee decision in writing. The decision letter will include: the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Participant.

The Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

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

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with PA Health & Wellness for an external review of a Grievance decision by a certified review entity (CRE) appointed by PID's BMC. The request must be filed in writing or orally within fifteen (15) days from the date the Participant receives the written notice of the Grievance decision.

Expedited Participant Grievances

A Participant has the right to request an Expedited Grievance review at any stage of the Grievance review process. Expedited Grievances may be requested with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature. No punitive action is taken against a Provider that requests an expedited resolution or supports a Participant's Grievance. In instances where the Participant's request for an Expedited Grievance is denied, the Grievance is transferred to the timeframe for standard resolution of Grievances.

Decisions for Expedited Grievances are issued within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Participant.

A decision letter will be sent to the Participant, Participant's representative, or Participant's Provider that will include: the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the Participant.

The Participant may file a request for an Expedited External Review within two (2) business days from the date the Participant receives PA Health & Wellness' expedited Grievance decision and/or a DHS Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the expedited Grievance decision. If denied, a written notice, using a DHS approved form, will be sent within two (2) business days of the decision to deny the expedited review.

External Participant Grievance Review Process

PA Health & Wellness establishes and maintains an external Grievance review process by which a Participant, their representative or a Provider, with the written consent of the Participant, may request an external review of a Grievance decision.

Any Grievance review that is not resolved wholly in favor of the Participant by PA Health & Wellness may be grieved by the Participant or the Participant's representative in an external review. A Participant, the Participant's representative, or Participant's Provider who filed the grievance has fifteen (15) days from receipt of the Grievance review decision to file a request for an external review with PA Health & Wellness. Within five (5) business days of receipt of the request for an external Grievance review, PA Health & Wellness must notify the Participant, Participant's representative, if applicable, or the Provider, and the PID's BMC that the request for external Grievance review has been filed. Within two (2) business days of receipt of the request for an external Grievance review PID's BMC will randomly assign a CRE to conduct the review and notify PA Health & Wellness and assigned CRE of the assignment.

The assigned external review entity reviews and issues a written decision within sixty (60) days of the filing of the request for an external Grievance review. The decision is sent to the Participant, the Participant's representative, or Provider, if the provider filed the grievance with Participant's written consent, PA Health & Wellness, and PID's BMC. The decision includes the credentials of the individual reviewer, a list of the information considered in reaching the decision, the basis and clinical rationale for the decision and a brief statement of the decision.

The Participant, the Participant's representative, or Participant's Provider have sixty (60) days from receipt of the decision to appeal to a court of competent jurisdiction.

PA Health & Wellness complies with the external review entity's decision.

Reversed Participant Grievance Resolution

In accordance with 42 CFR §438.424, if PA Health & Wellness or the External Review Entity decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, PA Health & Wellness authorizes the disputed services promptly and as expeditiously as the Participant's health condition requires. Additionally, in the event that services were continued while the appeal was pending, PA Health & Wellness provides reimbursement for those services in accordance with the terms of the final decision rendered by the External Review Entity and applicable regulations.

To file a request for an external Grievance review:

PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd
Mechanicsburg, PA 17050

Fair Hearing Process

A Participant or Participant's representative must file a Complaint or Grievance with PA Health & Wellness and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If PA Health & Wellness fails to provide written notice of a Complaint or Grievance decision within the time frames specified, the Participant is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of Pa Health & Wellness' first level Complaint decision or Grievance decision for any of the following:

- the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
- the denial of a requested service or item because the service or item is not a Covered Service;
- the reduction, suspension, or termination of a previously authorized service or item;
- the denial of a requested service or item but approval of an alternative service or item;
- the failure of PA Health & Wellness to provide a service or item in a timely manner, as defined by the Department;
- the failure of PA Health & Wellness to decide a Complaint or Grievance within the specified time frames;
- the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- the denial of payment after a service or item has been delivered because the service or item is not a Covered Service for the Participant; or
- the denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless PA Health & Wellness failed to provide written notice of the Complaint or Grievance decision within the time frames specified by the Department. Requests must be sent to:

Department of Human Services
OLTL/Forum Place 6th Floor
Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, Pennsylvania 17105-8025

A Participant who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

PROVIDER DISPUTES

PA Health & Wellness maintains a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The Provider dispute process excludes claims. The resolution of all issues regarding the interpretation of Department of Health approved Provider Agreements must be handled between the Provider and PA Health & Wellness and does not involve the Department of Health; therefore, these are not within the scope of the Department's Bureau of Hearings and Appeals (BHA). Additionally, the Department's BHA or its designee is not an appropriate forum for Provider Disputes/Appeals with PA Health & Wellness.

A Provider Dispute is a written communication to PA Health & Wellness, made by a Provider, expressing dissatisfaction with a PA Health & Wellness decision that directly impacts the Provider, excluding decisions concerning Medical Necessity and/or claims. Providers are allowed Thirty (30) days to file a dispute. If the issue being disputed is associated with dissatisfaction with PHW Policies or Procedures, the Provider should file a dispute within Thirty (30) Days of becoming aware of the issue.

A Provider Appeal is a written request from a Provider for reversal of a determination by PA Health and Wellness:

- a Provider credentialing denial;
- a claim denial; or
- a Provider agreement termination.

It is important to note that inquiries or appeals related to claims are handled separately from provider appeals or disputes through the Claims Reconsideration process. Please see the Claims Reconsideration Section of the Provider Billing Manual.

PA Health & Wellness' Informal and formal processes for settlement of Provider Disputes and Provider Appeals includes the following:

- Acceptance and usage of the Department's definition of Provider Appeals and Provider Disputes
- Time frames for submission and resolution of Provider Disputes and Provider Appeals
- Processes to ensure equitabilities for all Providers
- Mechanisms and time frames for reporting Provider Appeal decisions to PA Health & Wellness' administration, QM, Provider Relations and the Department
- Establishment of a PA Health & Wellness Committee to process formal Provider Appeals which provides:
    - At least one-fourth (1/4th) of the members of the Committee must be composed of Providers/peers
    - Committee participants have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues

- Access to data necessary to assist committee participants in making decisions
- Documentation of meetings and decisions of the Committee

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A Provider Appeal is a written request from a Provider for reversal of a determination made by PA Health & Wellness. Network Providers have Sixty (60) days to file a Provider Appeal from the date of determination by PA Health & Wellness. Provider Appeals include but are not limited to:

- Medical Necessity
- QM/UM sanctions
- Adverse credentialing/re-credentialing decisions
- Provider Terminations

It is important to note that inquiries or appeals related to claims are handled separately from provider appeals or disputes through the Claims Reconsideration process. Please see the Claims Reconsideration section of the Provider Billing Manual.

FRAUD, WASTE AND ABUSE

PA Health & Wellness takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with Pennsylvania and federal laws. PA Health & Wellness successfully operates a Special Investigations Unit (SIU). PA Health & Wellness performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims Manual located on our website. PA Health & Wellness performs retrospective audits which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify

PA Health & Wellness instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes
- Audit inspection authority of the Pennsylvania Office of Attorney General Medicaid Fraud Control pursuant to 42 CFR §438.230(3).

Types of Fraud:

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

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

PA Health & Wellness requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all PA Health & Wellness Participants. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a

state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or Participants' medication fraud.

FWA Training is available via our company website – we have a training program providers can download in PDF format. We also include FWA training in our Provider Orientation packets.

To report any Fraud, Waste and Abuse concerns please call the Fraud and Abuse Line at 1-866-685-8664.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, PA Health & Wellness Auditors request medical records for a defined review period. Providers have30 calendar days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the Provider. If the Provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, PA Health & Wellness will recover all amounts paid for the services in question.

PA Health & Wellness Auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the participant's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

PA Health & Wellness Auditors consider State and Federal laws and regulations, Provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, PA Health & Wellness will seek recovery of all overpayments. Depending on the number of services provided during the review period, PA Health & Wellness may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, PA Health & Wellness uses RAT-STATS 2007 Version 2, the OIG's statistical software

tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments. Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS and completing the extrapolation overpayment. Audit findings are reported to the Bureau of Program Integrity and the Office of the Attorney General Medicaid Fraud Control Section.

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a participant receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. PA Health & Wellness takes all reports of potential fraud, waste, and/or abuse very seriously and investigate all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, PA Health & Wellness may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Medical Assistance Provider Compliance Hotline

The Medical Assistance (MA) Provider Compliance Hotline, established by and located in the DHS Bureau of Program Integrity, is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in managed care within the Pennsylvania MA Program. The Hotline is staffed with medical professionals who are available from 8:30 a.m. to 3:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-English speaking interpreter services are available to provide assistance to callers and TTY services for persons with hearing impairment are also available.

Contact Information for Fraud and Abuse Reporting by telephone (includes TTY service): 1-866-379-8477

Self-Audit Protocol

Providers may voluntarily disclose overpayments or improper payments of MA funds to PA Health & Wellness, following the Self-Audit Protocol defined by the Commonwealth. Details on the Self-Audit Protocol may be found on the DHS website:

https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

QUALITY MANAGEMENT

PA Health & Wellness culture, systems and processes are structured around its mission to improve the health of all enrolled Participants. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all Participants, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, dental healthcare, over and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

PA Health & Wellness recognizes its legal and ethical obligation to provide Participants with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of Participants.

Where the Participant's condition is not amenable to improvement, PA Health & Wellness will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Participant. This will include the identification of Participants at-risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the PA Health & Wellness QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of Participants.

Program Structure

The PA Health & Wellness Board of Directors has the ultimate authority and accountability for the oversight of the quality of care and service provided to Participants. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Management Committee (QMC) is a senior management committee with PA Health & Wellness network physician representation that is directly accountable to the Board of Directors. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to Participants. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve participant outcomes, and the education of participants, providers and staff regarding the Quality and Medical Management programs.

The following committees report directly to the Quality Management Committee (QMC):

- Utilization Management Committee (UMC)
- Pharmacy &Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Complaints and Grievance Committee
- Provider Advocacy Committee (PRAC)

- Participant Advisory Committee (PAC)

In addition to the committees reporting to the QMC, PA Health & Wellness has sub-committees and workgroups that report to the above committees including, but not limited to:

- Peer Review Committee
- Dental Advisory Committee
- Behavioral Health Joint Operating Committee
- Health Education Advisory Committee

Provider Involvement

PA Health & Wellness recognizes the integral role practitioner involvement plays in the success of its QAPI Program. As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow the PA Health & Wellness to use their performance data. Practitioner involvement in various levels of the process is highly encouraged through Provider representation and participation on the Quality Committees. PA Health & Wellness encourages PCP, specialty, OB/GYN, Pharmacy, Dental, LTSS and Behavioral Health representation on key quality committees including, but not limited to, the QMC, UMC, P&T, Credentialing, Provider and Participant Advisory, as well as select ad-hoc committees.

Quality Assessment and Performance Improvement Program

Scope

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to PA Health & Wellness Participants. PA Health & Wellness's QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

PA Health & Wellness's primary QAPI Program goal is to improve Participants' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The PA Health & Wellness QAPI Program monitors the following:

- Acute and chronic care management
- Long-Term Services and Supports (LTSS)
- Coordination with Behavioral Health Managed Care Organizations (BH-MCO)
- Compliance with confidentiality laws and regulations
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency

- Marketing practices
- Participant enrollment and disenrollment
- Participant Complaint and Grievance System
- Participant experience
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including over, under and mis-utilization
- Service Coordination authorization LTSS and communication to providers

Patient Safety and Quality of Care

Patient Safety is a key focus of PA Health & Wellness QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a Participant.

PA Health & Wellness employees (including Medical Management staff, Participant Services staff, Provider Services, Complaint Coordinators, etc.), panel practitioners, facilities or ancillary Providers, Participants or Participant representatives, Medical Directors or the Board of Directors may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

PA Health & Wellness QMC reviews and adopts an annual QAPI Program and Work Plan aligned with PA Health & Wellness vision and goal and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving participant health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow PA Health & Wellness to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve health care for PA Health & Wellness Participants. The measures are physical health focused HEDIS measures, integrated behavioral health care, HEDIS measures, along with Commonwealth identified metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, PA Health & Wellness develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QMC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QMC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

PA Health & Wellness communicates activities and outcomes of its QAPI Program to both Participants and Providers through avenues such as the Participant newsletter, Provider newsletter, and the PA Health & Wellness web portal at PAHealthWellness.com.

At any time, PA Health & Wellness Providers may request additional information on the Health Plan programs, including a description of the QAPI Program and a report on PA Health & Wellness progress in meeting the QAPI Program goals, by contacting the Quality Improvement department.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual Provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by PA Health & Wellness quality committees (Quality Management and Utilization Management Committee, Credentialing Committee, Performance Improvement Committee and/or other committees involved in the quality program). This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- Participant complaint and grievance data.
- Utilization management data including emergency room visits/1000 and bed days/1000 reports.
- LTSS and service coordination data.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.

- Pharmacy data including use of generics or specific drugs.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across Health Plans. HEDIS gives purchasers and consumers the ability to distinguish between Health Plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Pennsylvania Department of Health contract.

As both the Pennsylvania and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the Health Plan, but to the individual provider. Pennsylvania purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its participants. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs, such as "Pay for Performance." These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the Health Plan. Measures calculated using administrative data may include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Participant medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of medical record reviews (see PA Health & Wellness website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores).

Measures typically requiring medical record review include diabetic HbA1c results, diabetic retinal eye exam, controlling high blood pressure, cervical cancer screening, transition of care, care for older adults, colon cancer screening and prenatal and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

Medical record review audits for HEDIS are usually conducted March through May each year. PA Health & Wellness QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on PA Health & Wellness' behalf may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Participant/patient. The MRR vendor will sign a HIPAA

compliant Business Associate Agreement with PA Health & Wellness which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes for HEDIS measures related to blood pressure, hemoglobin A1C, cholesterol, diabetic retinal eye exam, advance care planning, medication list and reviews, care for older adults' functional status and pain assessment, medication list and review, and lastly medication reconciliation post hospital discharge.
- CPT II coding helps track quality performance outcomes in a timelier manner, allowing for identification of care opportunities accurately and quickly deploying member interventions to improve member outcomes. It reduces administrative burden for providers by reducing chart collection/medical record submissions as well as facilitates timely and accurate Pay for Quality (P4Q) reporting.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Management Department at 1-844-626-6813.

Critical Incidents

Critical Incident

All medical Providers, Direct Care Providers and Service Coordinators (SC) are required by law to be mandatory reporters of Critical Incidents

Before a Critical Incident is reported, measures must be taken immediately to safeguard the Participant. This may include calling 911, contacting Adult Protective Services (Participants aged 18-59) or Older Adult Protective Services (Participants aged 60+), law enforcement, the fire department, or other authorities as appropriate. After the health and welfare of a Participant has been safeguarded, it needs to be determined if a Critical Incident is reportable or not. The health and welfare of the Participant must be ensured at all times.*

Within 24 hours of discovery of event occurrence, Providers are required to inform the Service Coordinator of the event.

Mandated reporters must report Critical Incidents via the Department's Enterprise Incident Management (EIM) System within 48 hours of the date and time of the discovery of the incident, excluding weekends and holidays. The forty-eight (48) hour clock begins at the time that the incident was discovered. If the incident was discovered on a weekend or holiday the clock would start at 12:00 a.m. on the first business following the discovery of the incident. Using the Department's Enterprise Incident Management System,

PA Health & Wellness must investigate incidents reported and report the outcomes of these investigations. PA Heath & Wellness along with the mandated reporter should conclude the investigation within 30 days of discovery of the incident. However, in some cases there may be an extended timeframe.

Mandated reporters must report in accordance with applicable requirements. PA Health & Wellness requires those defined as a mandated reporter to cooperate with the investigation of Critical Incidents. PA Health & Wellness will collaborate throughout the investigation process.

Pennsylvania Health and Wellness will review all reports to ensure that the Participant has been made safe, all agencies have been notified of the event, a full investigation has been conducted, and that there is no future risk to the individual or other Participants. If PA Health & Wellness determines that a full investigation has been conducted and all steps are completed, they will validate the report and close it for State review. If PA Health & Wellness cannot determine that the investigation and all subsequent steps are completed, they may choose to have a Quality Management designee conduct additional investigative steps including but not limited to: A site visit, record review, and interview of witnesses and/or the Participant. Once PA Health & Wellness has validated the report, the State Department of Human Services (DHS) may choose to close the investigation or conduct additional investigatory steps. At any point during the investigation the State's DPW may decide to conduct an independent investigation of the issue.

What are Critical Incidents?

Critical Incidents are events that jeopardize the Participant's health or welfare. The following are reportable Critical Incidents:

- Death (other than by natural causes)
- Serious Injury that causes a person severe pain; or significantly impairs person's physical or mental functioning, either temporarily or permanently.
- Hospitalization except in certain cases, such as hospital stays that were planned in advance
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but are not necessarily limited to:
    - Physical abuse, defined as a physical act by an individual that may cause physical injury to a Participant;
    - Psychological abuse, defined as an act, other than verbal, which may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a Participant;
    - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant;
    - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a Participant;
- Neglect, which includes the failure to provide a Participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm;

    - Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others.
- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts Participant rights.
- Service interruption, which includes any event that results in the Participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the Participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
- Medication errors that result in hospitalization, an emergency room visit or other medical intervention.
- For the purposes of Critical Incident reporting an emergency room visit is defined as the use of a hospital emergency room. This includes situations that are clearly emergencies, such as a serious injury, life-threatening medical conditions, medication errors, as well as those when an individual is directed to an emergency room in lieu of a visit to the PCP or as the result of a visit to the PCP. The use of an emergency room by an individual, in place of the physician's office, is not reportable.

Provider Preventable Serious Adverse Events (PSAEs)?

PA Health & Wellness requires all nursing facilities to identify Provider Preventable Conditions as defined in 42 C.F.R. § 447.26 and may not pay for services related to Provider Preventable Conditions unless the condition existed prior to the initiation of treatment for the Participant.

An event is a PSAE if **ALL** of the following criteria are present:
- The event was preventable
- The event was serious
- The event was within the control of the nursing facility.
- The event occurred as a result of an error or other system failure**

Nursing facilities are strongly encouraged to self-report the PSAE to PA Health & Wellness via fax at 1-844-873-7451 by submitting a copy of the Department of Health Report filed for the PSAE or may call PA Health & Wellness at 1-866-535-2545.

Please contact PA Health & Wellness or refer to the Department's website for additional information regarding Critical Incidents and PSAE:

http://dhs.pa.gov/searchresults/index.htm?q=critical+incidents
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_223343.pdf
http://dhs.pa.gov/searchresults/index.htm?q=Preventable+Serious+Adverse+Events

MEDICAL RECORDS REVIEW

PA Health & Wellness Providers must keep accurate and complete medical records. Such records will enable Providers to render the highest quality healthcare service to Participants. They will also enable PA Health & Wellness to review the quality and appropriateness of the services rendered. To ensure the Participant's privacy, medical records should be kept in a secure location.

PA Health & Wellness requires Providers to maintain all records for Participants for at least ten (10) years. See the Participant Rights section of this handbook for policies on Participant access to medical records. PA Health & Wellness may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and Participant complaint/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. PA Health & Wellness will work with any physician or Provider who scores less than 80% to develop an action plan for improvement. Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive Participant records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Participant's participating primary care physician or Provider, that document all medical services received by the Participant, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for participants in accordance with the following standards:

- Participant's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An appropriate history of immunizations is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with PA Health & Wellness' practice guidelines
- Appropriate subjective and objective information pertinent to the Participant's presenting complaints is documented in the history and physical
- Disposition and follow-up
- Reports of operative procedures and exised tissues

- Past medical history (for Participants seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters
- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the participant
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- Appropriate notations concerning use of tobacco, alcohol and substance use (for participants seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the Participant is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of Participant information and records protected
- Evidence that an Advance Directive has been offered to adults 18 years of age and older

Additionally, the LTSS Comprehensive Medical and Service Record should contain:

- Medication Record and Person-Centered Service Plan (PCSP), where applicable
- Services provided as per the PCSP
- Service Coordination contact notes
- Documentation of all aspects of patient care or participant service delivery

Nursing Facility records will also include:

- Substantiation of Preadmission Screening and Resident Review (PASRR)
- Documentation of specialized services delivery
- Evidence of education regarding Patient Rights and Responsibilities
- Acknowledgement that the Participant was informed of any patient pay liability
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts
- Other processes identified by either PA Health & Wellness or the Department.

Medical Records Release

All Participant medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Participant/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with PA Health & Wellness which allows them to collect PHI on our behalf. PHW requires its Network Providers to have mechanisms that guard against unauthorized or inadvertent disclosure of confidential information.

Medical Records Transfer for New Participants

All PCPs are required to document in the Participant's medical record attempts to obtain historical medical records for all newly assigned PA Health & Wellness participants. If the Participant or participant's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record. PHW will facilitate the transfer of Participant medical records among Providers, as necessary.

Access to Records and Audits by PA Health & Wellness

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit PA Health & Wellness or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least thirty (30) business days prior written notice by PA Health & Wellness or its designated representative, but not more than sixty (60) days following such written notice.

Electronic Medical Record (EMR) Access

Provider will grant PA Health & Wellness access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to PA Health & Wellness for this access.

REGULATORY MATTERS

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, creed, religion, national origin, age, disability ,ancestry, marital status, sex (including pregnancy, sexual orientation, and gender identity), MA status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental disability, except where medically indicated. Section 1557 builds on long-standing and

familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces

For more information, please visit http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

Chapter 1101. General Provisions

All PA Health & Wellness Providers must abide by the rules and regulations set forth under the General Provision of 55 PA Code, Chapter 1101. A complete outline of the General Provision is provided below with hyperlinks to the most recent version available from pacode.com.

Preliminary Provisions

1101.11. General provisions.

Definitions

1101.21. Definitions.
1101.21a. Clarification regarding the definition of ‘‘medically necessary’’—statement of policy.

Benefits

1101.31. Scope.
1101.31a. [Reserved].
1101.32. Coverage variations.
1101.33. Recipient eligibility.

Participation

1101.41. Provider participation and registration of shared health facilities.
1101.42. Prerequisites for participation.
1101.42a. Policy clarification regarding physician licensure—statement of policy.
1101.42b. Certificate of Need requirement for participation—statement of policy.
1101.43. Enrollment and ownership reporting requirements.

Responsibilities

1101.51. Ongoing responsibilities of providers.

Fees and Payments

Administrative Procedures

Violations