Member Rights ...................................................................................................................................... 55
Member Responsibilities...................................................................................................................... 57
Provider Rights...................................................................................................................................... 58
Provider Responsibilities ..................................................................................................................... 58

COMPLAINT AND GRIEVANCE PROCESS ........................................... 61
Member Complaints .............................................................................................................................. 61
Grievances ............................................................................................................................................. 63
Second Level Review ............................................................................................................................. 65
Expedited Grievances ............................................................................................................................. 65
External Grievance Process ..................................................................................................................... 66
Reversed Grievance Resolution .............................................................................................................. 66

WASTE, FRAUD AND ABUSE ............................................................... 67

QUALITY IMPROVEMENT .................................................................... 69
Program Structure................................................................................................................................. 70
Practitioner Involvement ......................................................................................................................... 70
Quality Assessment and Performance Improvement Program Scope and Goals ............................. 71
Patient Safety and Quality of Care .......................................................................................................... 72
Performance Improvement Process ....................................................................................................... 72
Healthcare Effectiveness Data and Information Set (HEDIS) .............................................................. 73

MEDICAL RECORDS REVIEW ............................................................. 74
Required Information ............................................................................................................................. 75
Medical Records Release ....................................................................................................................... 76
Medical Records Transfer for New Members ....................................................................................... 77
WELCOME

Welcome to Pennsylvania Health & Wellness, and thank you for being part of our network of physicians, hospitals and other healthcare professionals. We look forward to working with you to improve the health of our community, one person at a time.

About Us

Pennsylvania Health & Wellness is a Physical Health Managed Care Organization (PH-MCO) awarded a contract with the Commonwealth of Pennsylvania, Department of Human Services (DHS) to provide healthcare services to a portion of Medicaid members in Southeast, Lehigh/Capital, and Southwest Zones.

About This Manual

This manual contains comprehensive information about Pennsylvania Health & Wellness operations, benefits, policies and procedures. The most up-to-date version can always be viewed from our website PAHealthWellness.com. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices.

KEY CONTACTS

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

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member’s Pennsylvania Health & Wellness ID number or Medicaid ID number

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>[Phone number to be updated by 10/1/16]</td>
<td>[FAX number to be updated by 10/1/16]</td>
</tr>
<tr>
<td>Member Services</td>
<td>[Phone number to be updated by 10/1/16]</td>
<td>[FAX number to be updated by 10/1/16]</td>
</tr>
<tr>
<td>TDD/TTY: [Phone number to be updated by 10/1/16]</td>
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<tr>
<td>Authorization Request,</td>
<td>[Phone number to be updated by 10/1/16]</td>
<td>[FAX number to be updated by 10/1/16]</td>
</tr>
</tbody>
</table>

Pending Commonwealth Approval
Concurrent Review, Case Management  10/1/16  10/1/16

24 Hour Nurse Advice Line (24/7 Availability)  [Phone number to be updated by 10/1/16]  [FAX number to be updated by 10/1/16]

Department of Health & Hospitals  [Phone number to be updated by 10/1/16]

<table>
<thead>
<tr>
<th>Paper Claims Submission</th>
<th>Claim Appeals</th>
<th>Medical Necessity Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania Health &amp; Wellness</td>
<td>Pennsylvania Health &amp; Wellness</td>
<td>Pennsylvania Health &amp; Wellness</td>
</tr>
<tr>
<td><strong>Attn: Claims</strong></td>
<td><strong>Attn: Claim Appeals</strong></td>
<td><strong>Attn: Medical Necessity</strong></td>
</tr>
<tr>
<td>[PO Box to be updated by 10/1/16]</td>
<td>[PO Box to be updated by 10/1/16]</td>
<td>[Address to be updated by 10/1/16]</td>
</tr>
<tr>
<td>Farmington, MO 63640-3826</td>
<td>Farmington, MO 63640-3800</td>
<td></td>
</tr>
</tbody>
</table>

Electronic Claims Submission

Pennsylvania Health & Wellness  
c/o Centene EDI  
1-800-225-2573, ext. 6075525  
or by e-mail to: EDIBA@centene.com

**POPULATIONS SERVED**

Pennsylvania Health & Wellness will provide medical services to the following Medicaid eligible categories:

- Aged
- Disabled Children and Adults
- Children

Pending Commonwealth Approval
• Low-income Adults
• Medicare-Medicaid Eligibles (except partial duals age 21+)
• Foster Care Children

**VERIFYING ELIGIBILITY**

To verify member eligibility, please use one of the following methods:

1. **Log on to our Secure Provider Portal** at PAHealthWellness.com. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: Member name and date of birth, or member Medicaid ID and date of birth.

2. **Call our automated member eligibility IVR system.** Call [Phone number to be updated by 10/1/16] from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the member Medicaid ID and the month of service to check eligibility.

3. **Call Pennsylvania Health & Wellness Provider Services.** If you cannot confirm a member’s eligibility using the methods above, call our toll-free number at [Phone number to be updated by 10/1/16]. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name, member Medicaid ID, and member date of birth to verify eligibility.

Through Pennsylvania Health & Wellness’ Secure Provider Portal, PCPs are able to access a list of eligible members 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 date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. 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 member eligibility on the date of service.

All new Pennsylvania Health & Wellness members receive a Pennsylvania Health & Wellness member ID card. Members will keep their state issued ID card to receive services not covered by the plan (such as dental or hospice services). A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

**TIP**

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

Pending Commonwealth Approval
Member Identification Card

Whenever possible, members should present both their Pennsylvania Health & Wellness member 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 member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services at [Phone number to be updated by 10/1/16] immediately.

Members must also keep their state-issued Medicaid ID card in order to receive benefits not covered by Pennsylvania Health & Wellness.

Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week.

Please contact your Provider Relations Representative or our Provider Services department at [Phone number to be updated by 10/1/16] with any questions or concerns regarding the website.

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

- Prior Authorization List
- Forms
- Pennsylvania Health & Wellness Plan News
- Clinical Guidelines
- Provider Bulletins
- Contract Request Forms
- Provider Consultant Contact Information
- Provider Training Manual
- Provider Education Training Schedule

Secure Website

Pennsylvania Health & Wellness web portal services allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with Pennsylvania Health & Wellness staff. All providers and their office staff have the opportunity to

Pending Commonwealth Approval
register for our secure provider website in just 4-easy steps. Here, we offer tools that make obtaining and sharing information easy! It’s simple and secure! Go to PAHealthWellness.com to register. On the home page, select the Login link on the top right to start the registration process.

Through the secure site you can:

- Check member eligibility
- View members’ health record
- 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
- Verify authorization status
- View member health record
- View member gaps in care
- Contact us securely and confidentially
- Add/Remove account users
- Determine payment/check clear dates
- Add/Remove TINs from a user account
- EPSDT Reports
- View PCP Quality Incentive Report
- View and Print Explanation of Payment

Please contact a Provider Relations Representative for a tutorial on the secure provider portal.

GUIDELINES FOR PROVIDERS

Medical Home Model

Pennsylvania 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.

Pennsylvania 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 members of their own care and reduce avoidable costs over time. Pennsylvania Health & Wellness will actively partner with our providers, with community organizations, and groups representing our members to increase the numbers of providers who are recognized as medical homes (or committed to becoming recognized).

Pennsylvania 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:

Pending Commonwealth Approval
• Readiness survey of contracted providers
• Education on the process of becoming certified
• Resource tools and best practices.

Our secure Provider Portal offers tools to help support PCMH accreditation elements. These tools include:

• Online Care Gap Notification
• Member Panel Roster including member detail information

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

**Primary Care Practitioner (PCP)**

The Primary Care Practitioner (PCP) is the cornerstone of Pennsylvania Health & Wellness service delivery model. The PCP serves as the “Medical Home” for the member. The Medical Home concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes.

Pennsylvania Health & Wellness offers a robust network of primary care providers to ensure every member has access to a Medical Home within the required travel distance standards (50 mile radius of each member’s home).

We request that PCPs inform our Member Service department when a Pennsylvania Health & Wellness member misses an appointment so we can monitor and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Room services.
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
- Obstetrician or Gynecologist (OB/GYN)
- Rural Health Center (RHC)

Members with disabling conditions, chronic illnesses or Children with Special Health Care Needs may request that their PCP be a specialist. The designation of the specialist as a PCP must be in consultation with the current PCP, member, 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 specialty medical services consistent with the member’s disabling condition, chronic illness or Special Health Care Needs in accordance with the PCP responsibilities included in this manual.

Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Pennsylvania Health & Wellness DOES NOT guarantee any provider will receive a certain number of members. The PCP to member ratio shall not exceed the following:

- 1,000 members to a single PCP

PCPs interested in exceeding the member 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 members. These ratios apply to all RCOs.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Pennsylvania Health & Wellness Provider Services at [Phone number to be updated by 10/1/16]. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

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

PCP Assignment

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

1. Member’s geographic location
2. Member’s previous PCP, if known;
3. Other family member’s PCPs, if known
4. Special Health Care Needs, including pregnancy, if known
5. Special language and cultural considerations, if known

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician or other appropriate PCP, Pennsylvania Health & Wellness will assign one for her newborn within 30 calendar days after birth.

**Primary Care Practitioner (PCP) Responsibilities**

PCP’s responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked members with at least one hospital within the required network adequacy distance requirements
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions.
- Educate members on how to maintain healthy lifestyles and prevent serious illness.
- Provide screening, well care and referrals to community health departments and other agencies in accordance with DHH provider requirements and public health initiatives.
- Maintain continuity of each member’s health care by serving as the member’s medical home.
- Offer hours of operation no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
- Ensure follow-up and documentation of all referrals including services available under the State’s fee-for-service program.
• Collaborate with Pennsylvania Health & Wellness’s case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and other support services as needed for physical or mental illness.

• Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.

• Adhere to the EPSDT periodicity schedule for members under age 21.

• Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care.

• Share results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so services are not duplicated.

• Transfer members’ medical records to the receiving provider upon the change of PCP at the request of the new PCP and as authorized by the member within 30 calendar days of the date of the request.

• Actively participate in and cooperate with all Pennsylvania Health & Wellness quality initiatives and programs.

• Provide notice to Pennsylvania Health & Wellness of any updates necessary to the physician directory such as new address, new phone number, or change in group practice affiliation.

**Referrals**

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

The PCP must obtain prior authorization from Pennsylvania Health & Wellness Plan for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein except for family planning, emergency room, and tabletop x-ray services. A provider is also required to promptly notify Pennsylvania Health & Wellness when prenatal care is rendered.
Pennsylvania Health & Wellness encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their members’ 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.

**Specialist Responsibilities**

Pennsylvania 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 members’ care and ensure the referred specialty physician is a participating provider within the Pennsylvania 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 Pennsylvania Health & Wellness referral guidelines.

Emergency admissions will require notification to Pennsylvania Health & Wellness’s 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 Pennsylvania Health & Wellness.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from Pennsylvania Health & Wellness Medical Management Department (“Medical Management”) if needed before providing services
- Coordinate the member’s care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care
- Maintain the confidentiality of medical information

Pennsylvania 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 Pennsylvania Health & Wellness and the provider in the provider contract.
Mainstreaming

Pennsylvania Health & Wellness considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility
- Providing an Pennsylvania Health & Wellness member 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 members (examples: different waiting rooms or appointment times or days)

Appointment Accessibility and Access Standards

Pennsylvania Health & Wellness follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Pennsylvania Health & Wellness monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

<table>
<thead>
<tr>
<th>TYPE OF APPOINTMENT</th>
<th>SCHEDULING TIME-FRAME</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Providers</td>
<td></td>
</tr>
<tr>
<td>Life-threatening emergency care</td>
<td>Immediate and available 24 hours a day, seven days a week</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours of presentation or request</td>
</tr>
<tr>
<td>Routine appointments</td>
<td>Within 10 business days.</td>
</tr>
<tr>
<td>Health assessment/general physical examinations and first examinations</td>
<td>Within three (3) weeks of enrollment or request</td>
</tr>
<tr>
<td>Routine pregnancy well care</td>
<td>Within 15 calendar days of request</td>
</tr>
<tr>
<td>Primary Care Provider, Maternity, and Specialist</td>
<td>Office wait times</td>
</tr>
<tr>
<td>Walk-in</td>
<td>Within two hours or schedule and appointment within the standards of appointment availability</td>
</tr>
<tr>
<td>Previously scheduled appointment</td>
<td>Within one hour of appointment</td>
</tr>
<tr>
<td>Life-threatening emergency</td>
<td>Immediate</td>
</tr>
</tbody>
</table>
Pennsylvania Health & Wellness offers a comprehensive network of PCPs, Specialist Physicians, Hospitals, Diagnostic and Ancillary Services Providers to ensure every member has access to covered services. Below are the travel distance and access standards that Pennsylvania Health & Wellness utilizes to monitor its network adequacy:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Southeast, Lehigh/Capital, and Southwest Zones</th>
</tr>
</thead>
</table>
| PCP                              | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes                                                          |
| Pediatricists                    | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes                                                          |
| General Surgery                  | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes  
• Choice of 2 providers with anesthesia privileges/certificates or pay out of network |
| Obstetrics & Gynecology          |                                                                                                              |
| Cardiology                       |                                                                                                              |
| Pharmacy                         |                                                                                                              |
| Orthopedic Surgery               |                                                                                                              |
| General Dentistry                |                                                                                                              |
| Oncology                         | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes  
• Choice of 2 providers with anesthesia privileges/certificates or pay out of network |
| Physical Therapy                 | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes  
• Choice of 2 providers with anesthesia privileges/certificates or pay out of network |
| Radiology                        | • Urban: 2 in 30 minutes  
• Rural: 2 in 60 minutes  
• Choice of 2 providers with anesthesia privileges/certificates or pay out of network |
| Oral Surgery                     |                                                                                                              |
| Nursing Facility                 | • Urban: 1 in 30 minutes plus 1 within region  
• Rural: 1 in 60 minutes plus 1 within region                                            |
| Dermatology                      |                                                                                                              |
| Neurology                        |                                                                                                              |
| Otolaryngology                   |                                                                                                              |
| Urology                          |                                                                                                              |
| Hospitals                        | • Urban: 1 in 30 minutes plus 1 within region  
• Rural: 1 in 60 minutes plus 1 within region                                            |

Pending Commonwealth Approval
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Southeast, Lehigh/Capital, and Southwest Zones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia for Dental Care</td>
<td>• 2 dentist in network or pay out of network</td>
</tr>
<tr>
<td>Special health needs members</td>
<td>• 2 available providers or allow out of network provider</td>
</tr>
<tr>
<td>Rehabilitation Facilities</td>
<td>• 2 in network</td>
</tr>
<tr>
<td>CNMs/NPs</td>
<td>• Demonstrate good faith effort</td>
</tr>
<tr>
<td>FQHCs/RHCs</td>
<td>• Where they exist, must meet 1 in 30 Urban and 1 in 60 Rural. Or demonstrate good faith effort</td>
</tr>
<tr>
<td>All other Specialties and subspecialties</td>
<td>• 2 providers within the Health Zone</td>
</tr>
</tbody>
</table>

**Covering Providers**

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another Pennsylvania 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 Pennsylvania Health & Wellness network provider, he/she should be paid as a non-participating provider.

**Telephone Arrangements**

PCPs and Specialists must:

- Answer the member’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member 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

Pending Commonwealth Approval
• 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 member’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 member receiving urgent or emergent care.

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

24-Hour Access

Pennsylvania 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 members 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, or
  - 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 members.

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; and

• A Clinician returning after-hours calls outside 30 minutes.

The selected method of 24-hour coverage chosen by the member 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.

Pennsylvania Health & Wellness will monitor providers’ offices After-Hour Coverage through surveys and through mystery shopper calls conducted by Pennsylvania Health & Wellness Provider Network staff.

**Hospital Responsibilities**

Pennsylvania Health & Wellness utilizes a network of hospitals to provide services to Pennsylvania Health & Wellness members. 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 no later than the close of the next business day after the member’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 Pennsylvania Health & Wellness Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member’s name, Medicaid ID, presenting symptoms/diagnosis, DOS, and member’s phone number.
- Notify Pennsylvania Health & Wellness Medical Management department of all admission within one business day.
- Notify Pennsylvania Health & Wellness Medical Management department of all newborn deliveries within two business days of the delivery

**Advance Directives**

Pennsylvania Health & Wellness is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. Pennsylvania 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.

PCPs and providers delivering care to Pennsylvania Health & Wellness members must ensure adult members 18 years of age and older 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.
Pennsylvania Health & Wellness recommends to its PCPs and physicians that:

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

If an advance directive exists, the physician should discuss potential medical emergencies with the member 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.

**Voluntarily Leaving the Network**

Providers must give Pennsylvania 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 member’s new provider upon request and facilitate the member’s transfer of care at no charge to Pennsylvania Health & Wellness or the member.

Pennsylvania Health & Wellness will notify affected members 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 Pennsylvania Health & Wellness 60 days prior written notice of voluntary termination following the terms of their participating agreement with our health plan.

**Cultural Competency**

Cultural competency within Pennsylvania 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.

Pennsylvania Health & Wellness is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members 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 member 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

Pennsylvania Health & Wellness will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices. Network providers must ensure:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the member’s race/ethnicity and language and its impact/influence on the member’s health or illness
- Office staff that routinely interact with members 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-specific member information. Staff will also explain race/ethnicity categories to a
member so that the member is able to identify the race/ethnicity of themselves and their children

- Treatment plans are developed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member’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.

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Pennsylvania Health & Wellness is committed to helping you reach this goal. Take into consideration the following as you provide care to the Pennsylvania Health & Wellness members:

- 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.

**BENEFIT EXPLANATIONS AND LIMITATIONS**

Pennsylvania 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 [Phone number to be updated by 10/1/16]. A Provider Service Representative will be happy to assist you.

Pennsylvania 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

This list is not intended to be an all-inclusive list of covered services but it substantially provides 2016 guidelines. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Benefits for 2017 will be published when available.

<table>
<thead>
<tr>
<th>Service</th>
<th>Adult Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Service</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>No limits</td>
</tr>
<tr>
<td>Physician Services and Medical and Surgical Services provided by a Dentist</td>
<td>No limits</td>
</tr>
<tr>
<td>Certified Registered Nurse Practitioner</td>
<td>No limits</td>
</tr>
<tr>
<td>Federally Qualified Health Center/Rural Health Clinic</td>
<td>No limits except for Dental Care Services as described below</td>
</tr>
<tr>
<td>Independent Clinic</td>
<td>No limits</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic</td>
<td>No limits</td>
</tr>
<tr>
<td>Podiatrist Services</td>
<td>No limits</td>
</tr>
<tr>
<td>Chiropractor Services</td>
<td>No limits</td>
</tr>
<tr>
<td>Optometrist Services</td>
<td>2 visits (exams) per calendar year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.</td>
</tr>
<tr>
<td>Radiology (For example: X-Rays, MRIs, CTs)</td>
<td>No limits</td>
</tr>
<tr>
<td><strong>Dental Care Services</strong></td>
<td>Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception</td>
</tr>
<tr>
<td>Outpatient Hospital Short Procedure Unit (SPU)</td>
<td>No limits</td>
</tr>
<tr>
<td>Outpatient Ambulatory Surgical Center (ASC)</td>
<td>No limits</td>
</tr>
<tr>
<td>Service</td>
<td>Adult Benefit Package</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Ambulatory Surgical Center (ASC)</td>
<td>Only to and from MA covered services</td>
</tr>
<tr>
<td>Family Planning Clinic, Services and Supplies</td>
<td>No limits</td>
</tr>
</tbody>
</table>
| Renal Dialysis                               | • Initial training for home dialysis is limited to 24 sessions per patient per calendar year.  
• Backup visits to the facility limited to no more than 75 per calendar year. |
<table>
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<tr>
<th>Emergency Services</th>
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<tbody>
<tr>
<td>Emergency Room</td>
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<tr>
<td>Ambulance</td>
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<tr>
<th>Hospitalization</th>
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<tbody>
<tr>
<td>Inpatient Acute Hospital</td>
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<tr>
<td>Inpatient Rehab Hospital</td>
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<tr>
<th>Maternity and Newborn</th>
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</thead>
<tbody>
<tr>
<td>Maternity – Physician, Certified Nurse Midwives, Birth Centers</td>
</tr>
</tbody>
</table>

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<tr>
<th>Prescription Drugs</th>
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<tbody>
<tr>
<td>Prescription Drugs</td>
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<tr>
<td>Nutritional Supplements</td>
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<tr>
<th>Rehabilitation and Habitation Services and Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>Home Health Care</td>
</tr>
<tr>
<td>ICF/IID and ICF/ORC</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
</tr>
<tr>
<td>Eyeglass Frames</td>
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Pending Commonwealth Approval
Pending Commonwealth Approval

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Lenses</td>
<td>Limited to individuals with aphakia 4 lenses per calendar year</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>No limits</td>
</tr>
<tr>
<td>Therapy (Physical, Occupational, Speech)-</td>
<td>Only when provided by a hospital, outpatient clinic, or home health provider</td>
</tr>
<tr>
<td>Rehabilitative</td>
<td></td>
</tr>
<tr>
<td>Therapy (Physical, Occupational, Speech)-</td>
<td>Only when provided by a hospital, outpatient clinic, or home health provider</td>
</tr>
<tr>
<td>Habilitative</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>No limits</td>
</tr>
<tr>
<td>Preventative / Wellness Services and Chronic Care</td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>70 visits per calendar year</td>
</tr>
</tbody>
</table>

**Special Services to Assist Members**

**Non-Emergent Medical Transportation**

For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, Pennsylvania Health & Wellness will require the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home. Pennsylvania Health & Wellness requests its participating providers including its transportation vendor to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

**Women’s Health Care**

Pennsylvania Health & Wellness will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the member’s PCP if the provider is not a women’s health specialist. Members 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, members 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.

Pennsylvania Health & Wellness will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

Pending Commonwealth Approval
NETWORK DEVELOPMENT AND MAINTENANCE

Pennsylvania 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 members, both adults and children, without excessive travel requirements, and that is in compliance with DHH’s access and availability requirements.

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

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

Specialists

- Allergy and Asthma
- Anesthesiology
- Cardiology
- Dermatology
- General Dentistry
- General Surgery
- Neurology
- Neurosurgery
- Nursing Facility
- Obstetrics & Gynecology
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopedic Surgery
- Otolaryngology
- Pharmacy
- Physical Therapy
- Radiology
- Rehabilitation Medicine
- Urology

Facilities:

- Hospitals
- Laboratory services
- End state renal disease treatment and transplant centers
- Independent radiology centers

In the event Pennsylvania Health & Wellness’s network is unable to provide medically necessary services required under the contract, Pennsylvania 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.

Pending Commonwealth Approval
For assistance in making a referral to a specialist or subspecialties for a Pennsylvania Health & Wellness member, please contact our Medical Management team at [Phone number to be updated by 10/1/16] 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 member
- filed a complaint against us
- appealed a decision of ours

Tertiary Care

Pennsylvania Health & Wellness offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical sub specialists available 24-hours per day in the geographical service area. In the event Pennsylvania Health & Wellness’s network is unable to provide the necessary tertiary care services required, Pennsylvania 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.

MEDICAL MANAGEMENT

Pennsylvania 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, case management, population management, and quality review. The department clinical services are overseen by the Pennsylvania Health & Wellness medical director (“Medical Director”). The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact Medical Management at [phone number to be updated by 10/1/16].

Medical Necessity

Medically Necessary — a service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:
• The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
• The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
• The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

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 Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

**Complex Care Management Program**

Pennsylvania Health & Wellness case management model is designed to help your Pennsylvania Health & Wellness members obtain needed services, whether they are covered within the Pennsylvania 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 members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. It is the PCP’s responsibility to contact Care Management for updates. 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 Pennsylvania Health & Wellness members. 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 Pennsylvania Health & Wellness members that you think can benefit from the addition of a Pennsylvania Health & Wellness care management team member.

To contact a care manager call: [phone number to be updated by 10/1/16]

**High Risk 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 members and providing care management to high and moderate risk members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead care manager for members 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 members, and recommending interventions. These physicians will provide input to Pennsylvania Health & Wellness Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Pennsylvania Health & Wellness offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member 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 Pennsylvania Health & Wellness care manager who will check for eligibility. The care manager will assist the member 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 member and do an assessment regarding compliance. The nurse will remain in contact with the member 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 Pennsylvania Health & Wellness care management department for enrollment in the obstetrical program.

**Complex Teams**

These teams will be led by licensed registered nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and

Pending Commonwealth Approval
socioeconomic impacts on their ability to access services. The complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as HIV, diabetes, CHF, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in care management.

**MemberConnections® Program**

MemberConnections is Pennsylvania Health & Wellness outreach program designed to provide education to our members 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 Pennsylvania Health & Wellness and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Pennsylvania Health & Wellness within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who call the Pennsylvania Health & Wellness Customer Service department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify members 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 Pennsylvania 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 Pennsylvania Health & Wellness.

**Home Connections:** MemberConnections Representatives are available on a full-time basis whenever a need or request from a care manager, member, or provider. All home visits are unscheduled due to the fact that the care manager has been unable to make contact with the member. Some home visits can be scheduled when it involves them delivering a cell phone to the member in order to have easier access to the member. 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.

Pending Commonwealth Approval
Phone Connections: MemberConnections Representatives may contact new members or members 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 members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member’s home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan care manager, PCP, specialty physician, 24/7 nurse advice hotline, 911, or other members of their health care team.

To contact the MemberConnections Team call: [Phone number to be updated by 10/1/16].

Chronic Care/Disease Management Programs

As a part of Pennsylvania Health & Wellness services, Chronic Care Management Programs (CCMP) is offered to members. 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.

Pennsylvania 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 members’ self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for chronic care management:

- Call: Pennsylvania Health & Wellness Health Coaches at [Phone number to be updated by 10/1/16]
- Online: PAHealthWellness.com

Pending Commonwealth Approval
Early and Periodic Screening, Diagnostic & Treatment

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision, dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population.

Pennsylvania Health & Wellness and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Pennsylvania state regulations and AMA policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care.

This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein.

The following minimum elements are to be included in the periodic health screening assessment:

1. Comprehensive health and development history (including assessment of both physical and mental development);
2. Comprehensive unclothed physical examination;
3. Immunizations appropriate to age and health history;
4. Assessment of nutritional status;
5. Laboratory tests (including finger stick hematocrit, urinalysis [dip-stick], sickle cell screen, if not previously performed); blood lead levels must be tested pursuant to the EPSDT provider manual.
6. Developmental assessment;
7. Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;
8. Dental screening and services coordinated through FFS
9. Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids;
10. Health education and anticipatory guidance, and

Pending Commonwealth Approval
Provision of all components of the EPSDT service must be clearly documented in the PCP’s medical record for each member.

**Emergency Care Services**

Pennsylvania 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. serious impairments of bodily functions, or
3. serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a).

Members may access emergency services at any time without prior authorization or prior contact with Pennsylvania Health & Wellness. Providers should inform members 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 Pennsylvania Health & Wellness’s 24 hour nurse advice hotline for assistance; however, this is not a requirement to access emergency services. Pennsylvania Health & Wellness contracts with emergency services providers as well as non-emergency providers who can address the member’s non-emergency care issues occurring after regular business hours or on weekends.

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

1. A member 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 member to seek emergency services.

Once the member’s emergency medical condition is stabilized, Pennsylvania Health & Wellness requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

Pending Commonwealth Approval
Value-Added Services

CentAccount™

Pennsylvania Health & Wellness will incent members for healthy choices/behaviors with CentAccount™, our innovative reward program for preventive/wellness care. We make earning rewards easy: Members receive a proprietary CentAccount Card after their first qualified service, and subsequent rewards load automatically. Members use cards to buy health related items including groceries and personal care items.

NurseWise

Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

NurseWise is our 24-hour, 7 day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the NurseWise service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in the community after hours, when the Pennsylvania Health & Wellness Services department is closed. The NurseWise staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or NurseWise at [phone number to be updated by 10/1/16].

Clinical Practice Guidelines

Pennsylvania Health & Wellness clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Pennsylvania 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.

Pennsylvania 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 Improvement Program. Following is a sample of the clinical practice guidelines adopted by Pennsylvania Health & Wellness.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes

Pending Commonwealth Approval
For links to the most current version of the guidelines adopted by Pennsylvania Health & Wellness, visit our website at PAHealthWellness.com.

**Utilization Management**

The Pennsylvania Health & Wellness Utilization Management Program (UMP) is designed to ensure members of Pennsylvania 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 members across all eligibility types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care and ancillary care services.

Pennsylvania Health & Wellness UMP seeks to optimize a member’s health status, sense of well-being, productivity, and access to quality health care, 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 members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Pennsylvania Health & Wellness members 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 members/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. Pennsylvania Health & Wellness providers are contractually prohibited from holding any Pennsylvania Health & Wellness member financially liable for any service administratively denied by Pennsylvania 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 table top x-rays.

Services That Require Prior Authorization

Ancillary Services
- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment
- 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
- Therapy Services
- 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 NIA, i.e. CT, MRI, PET
- Obstetrical ultrasound — Two allowed in nine months; prior authorization required for additional u/s except if rendered by a perinatologist
- Pain management
- Specific procedures identified in the Pre-Auth Needed 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
- Skilled Nursing facilities
- Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review
• Outpatient Programs

The above list is not all inclusive. Please visit PAHealthWellness.com and use the “Pre-Auth Needed?” tool to determine if a service requires Prior Authorization.

**Procedures for Requesting a Prior-Authorization**

The preferred method for submitting authorizations is through the secure provider portal at PAHealthWellness.com. The provider must be a registered user on the secure provider portal. If the provider is not already a registered user on the secure provider 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 [phone number to be updated by 10/1/16]. 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 Prior Authorization fax forms posted on PAHealthWellness.com 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.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled admissions</td>
<td>Prior Authorization required five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Elective outpatient services</td>
<td>Prior Authorization required five business days prior to the elective outpatient admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification within two business days</td>
</tr>
<tr>
<td>Observation – 23 hours or less</td>
<td>Notification within one business day for non-participating providers</td>
</tr>
<tr>
<td>Observation – greater than 23 hours</td>
<td>Requires inpatient prior authorization within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification within two business day</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>Notification within one business day, with delivery outcome</td>
</tr>
<tr>
<td>Newborn admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU) admissions</td>
<td>Prior Authorization within one business day</td>
</tr>
</tbody>
</table>

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.
**Authorization Determination Timelines**
Pennsylvania Health & Wellness decisions are made as expeditiously as the member’s health condition requires.

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice/Urgent</td>
<td>72 hours</td>
</tr>
<tr>
<td>Preservice/Non-Urgent</td>
<td>2 business days of receipt of all necessary information not to exceed 14 calendar days</td>
</tr>
<tr>
<td>Concurrent review</td>
<td>24 hours</td>
</tr>
</tbody>
</table>

**Clinical Information**
Pennsylvania 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), Pennsylvania 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 member.

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

- Member’s name, member 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 Pennsylvania 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**

Pennsylvania Health & Wellness affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Pennsylvania Health & Wellness does not reward practitioners or other individuals for issuing denials of service or care.

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 member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Pennsylvania Health & Wellness Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member’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**

Pennsylvania 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 member’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 [phone number to be updated by 10/1/16]. 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 Pennsylvania Health & Wellness main toll-free phone number at [phone number to be updated by 10/1/16] and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals with the member’s consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Pending Commonwealth Approval
Second Opinion

Members or a healthcare professional with the member’s consent may request and receive a second opinion from a qualified professional within the Pennsylvania Health & Wellness network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Out-of-network and in-network providers require prior authorization by Pennsylvania 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

Pennsylvania 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 Pennsylvania 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 [phone number to be updated by 10/1/16].

Notification of Pregnancy

Members that become pregnant while covered by Pennsylvania Health & Wellness may remain a Pennsylvania Health & Wellness member during their pregnancy. The managing physician should notify the Pennsylvania Health & Wellness prenatal team by completing the Notification of Pregnancy (NOP) form 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 member’s attending physician. The Concurrent Review Nurse will review the member’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 business day of receipt of clinical information. For length of stay extension request, clinical information must be submitted by 3:00 p.m. CST 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 Pennsylvania Health & Wellness within two 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 member, but for which authorization and/or timely notification to Pennsylvania Health & Wellness was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member 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.

**Speech Therapy and Rehabilitation Services**

Pennsylvania Health & Wellness offers our members 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 Pennsylvania 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 members, Pennsylvania Health & Wellness is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA 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 NIA and obtain authorization, please call [phone number to be updated by 10/1/16] and follow the prompt for radiology authorizations. NIA 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

Pennsylvania Health & Wellness, in collaboration with NIA Magellan, 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, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA Magellan 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. NIA Magellan 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 members, 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 NIA Magellan:**

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

To reach NIA and obtain authorization, please call [phone number to be updated by 10/1/16]] and follow the prompt for radiology and cardiac authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

**PHARMACY**

Pennsylvania Health & Wellness is committed to providing appropriate, high quality, and cost effective drug therapy to all Pennsylvania Health & Wellness members. We work with providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are covered.

Pennsylvania Health & Wellness covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a Pennsylvania Health & Wellness provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or maximum quantities.

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

**Working With the Pharmacy Benefit Manager (PBM)**

Pennsylvania Health & Wellness works with US Script to administer pharmacy benefits, including the prior authorization process. Certain drugs require prior authorization to be approved for payment by Pennsylvania Health & Wellness.

These include:
• All medications not listed on the PDL
• Some Pennsylvania Health & Wellness preferred drugs (designated PA on the PDL)

Drug Prior Authorization request are available at US Script through phone, fax or online.

1. US Script Telephonic Prior Authorization
   a. Providers may call US Script to initiate a prior authorization by calling [phone number to be updated by 10/1/16]

2. FAX
   b. Fax to US Script at 1-866-399-0929.
   c. Once approved, US Script notifies the prescriber by fax.
   d. If the clinical information provided does not explain the reason for the requested PA medication, US Script responds to the prescriber by fax, offering PDL alternatives.

3. Online PA
   a. CoverMyMeds is an online drug prior authorization (PA) program through US Script that allows prescribers to begin the PA process electronically. Prescribers locate the correct form, fill it out online, and then submit it to US Script via fax. CoverMyMeds simplifies the PA submission process by automating drug prior authorizations for any medication
   b. CoverMyMeds can be found at https://www.uscript.com/covermymeds

For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the US Script Pharmacy Help Desk at: 1-800-460-8988.

Preferred Drug List (PDL)
The Pennsylvania Health & Wellness Preferred Drug List (PDL) can be found online at PAHealthWellness.com, and describes the circumstances under which contracted pharmacy providers will be reimbursed for medications dispensed to members covered under the program. All drugs covered under the Pennsylvania Medicaid program are available for Pennsylvania Health & Wellness members. The PDL includes all drugs available without PA and those agents that have the restrictions of Step Therapy (ST). The PA list includes those drugs that require prior authorization for coverage. The PDL applies to drugs a member receives at retail pharmacies. The PDL is continually evaluated by the Pennsylvania Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-
effective use of medications. The Committee is composed of the Pennsylvania Health & Wellness Medical Director, Pennsylvania Health & Wellness Pharmacy Director, and several Pennsylvania primary care physicians, pharmacists, and specialists by Pennsylvania Health & Wellness. The PDL 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 member or others.

The Pennsylvania Health & Wellness 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.

**Pharmacy and Therapeutics Committee (P&T)**

The Pennsylvania Health & Wellness Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the PDL. The Committee is composed of the Pennsylvania Health & Wellness Medical Director, Pennsylvania Health & Wellness Pharmacist, and several community based primary care physicians and specialists. The primary purpose of the Committee is to assist in developing and monitoring the Pennsylvania Health & Wellness PDL and to establish programs and procedures that promote the appropriate and cost-effective use of medications. The P&T Committee schedules meetings at least twice yearly, and coordinates reviews with a national P&T Committee which meets at least 4 times a year. Changes to the Pennsylvania Health & Wellness PDL are done in conjunction with the approval of the Commonwealth of Pennsylvania. Pennsylvania Health & Wellness will meet with the Commonwealth quarterly to review any proposed changes and update the PDL and prior authorization lists accordingly based on the results of both the Pennsylvania Health & Wellness P&T Committee and the requirements from the Commonwealth of Pennsylvania. Pennsylvania Health & Wellness will follow all State policies regarding member notification when changes are made to the PA list.

**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 Pennsylvania Health & Wellness. Experimental drugs and investigational drugs are not eligible for coverage.

**Prior Authorization Process**

The Pennsylvania Health & Wellness PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the Pennsylvania Health & Wellness PDL for their patients who are members of Pennsylvania Health & Wellness. Some drugs will require PA 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

Pending Commonwealth Approval
authorization. If a request for prior authorization is needed the information should be submitted by the
physician/clinician to US Script on the Pennsylvania Health & Wellness/US Script form: Medication Prior
Authorization Request Form. This form should be faxed to US Script at 1-866-399-0929. This document is
& Wellness will cover the medication if it is determined that:

1. There is a medical reason the member needs the specific medication.

2. Depending on the medication, other medications on the PDL have not worked.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the
Pennsylvania Health & Wellness P&T Committee. Once approved, US Script notifies the
physician/clinician by fax. If the clinical information provided does not meet the coverage criteria for the
requested medication Pennsylvania Health & Wellness we will notify the member and
physician/clinician of alternatives and provide information regarding the appeal process.

The P&T committee has reviewed and approved, with input from its members and in consideration of
medical evidence, the list of drugs requiring prior authorization. This PDL attempts to provide
appropriate and cost-effective drug therapy to all members covered under the Pennsylvania 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.

**US Script Contact Information:**

Prior Authorization Fax 1-866-399-0929

Prior Authorization Phone [phone number to be updated by 10/1/16]

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

**72-Hour Emergency Supply Policy**

Commonwealth and federal law require that a pharmacy dispense a 72-hour (3-day) 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. The pharmacy must call the US Script Pharmacy Help Desk at [phone number to be
updated by 10/1/16] for a prescription override to submit the 72-hour medication supply for payment.
**Newly Approved Products**

We review new drugs for safety and effectiveness for the first 12 months before adding them to the Pennsylvania Health & Wellness PDL. During this period, access to these medications will be considered through the PA review process. If Pennsylvania Health & Wellness does not grant prior authorization we will notify the member and physician/clinician and provide information regarding the appeal process.

**Step Therapy**

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

**Benefit Exclusions**

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

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Immunizations and vaccines (except flu vaccine)
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Infusion therapy and supplies
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence

DESI drugs products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established. Commonwealth programs may allow coverage of certain DESI drugs. Any DESI drugs that are covered are listed in the PDL.

**Injectable Drugs**

Injections that are self-administered by the member and/or a family member and appear on the PDL are covered by the Pennsylvania Health & Wellness pharmacy program. Insulin pens, Glucagon Kit, Epi-pen, Ana-Kit, Imitrex, and Depo-Provera IM are covered by Pennsylvania Health & Wellness and do not

Pending Commonwealth Approval
require a prior authorization. Pre-filled insulin cartridges and syringes require prior authorization. All other injectables require prior authorization.

_AcariaHealth – Biopharmaceuticals and Injectables_

AcariaHealth is the provider of biopharmaceuticals and injectables for Pennsylvania Health & Wellness. Most injectables require PA to be approved for payment. Our Medical Director oversees the clinical review. Pennsylvania Health & Wellness provides a number of biopharmaceutical products through the Biopharmaceutical Program. Most biopharmaceuticals and injectables require a PA to be approved for payment by Pennsylvania Health & Wellness; however, PA requirements are programmed specific to the drug as indicated in the list provided in the Biopharmaceutical Program document located on the Pennsylvania Health & Wellness website at PAHealthWellness.com. Follow these guidelines for the most efficient processing of your authorization requests.

Providers can request that AcariaHealth deliver the specialty drug to the office/member. If you want AcariaHealth to deliver the specialty drug to the office/member:

1. Fax the AcariaHealth PA form to 1-855-217-0926 for prior authorization.
2. If approved, AcariaHealth will contact the provider or member for delivery confirmation.

_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 must have elapsed before the prescription can be refilled. A prescription can be filled after 26 days. Dispensing outside the quantity limit (QL) or age limits (AL) requires PA. Pennsylvania Health & Wellness may limit how much of a medication you can get at one time. If the physician/clinician feels a member has a medical reason for getting a larger amount, he or she can ask for PA. If Pennsylvania Health & Wellness does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process. Some medications on the Pennsylvania Health & Wellness PDL may have AL. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns and quality standards of care. The AL aligns with current FDA alerts for the appropriate use of pharmaceuticals.

_Mandatory Generic Substitution_

When generic drugs are available, the brand name drug will not be covered without Pennsylvania Health & Wellness PA. Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the member or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for PA. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the member needs the particular brand name drug. If Pennsylvania Health & Wellness does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process. The provision is waived for the following products due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature: Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine,
Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.

**Over-The-Counter Medications**

The pharmacy program covers a large selection of OTC medications. All covered OTC medications appear in the PDL. All OTC medications must be written on a valid prescription by a licensed physician/clinician in order to be reimbursed.

**US Script Contacts - Prior Authorization**

Fax: 1-866-399-0929  
Web: usscript.com  
Phone: [Phone number to be updated by 10/1/16] (Monday - Friday 10:00 a.m.-5:00 p.m. EST)

**Mailing Address**

US Script  
5 River Park Place East, Suite 210  
Fresno, CA 93720

When calling, please have member information, including Medicaid ID number, member 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 members to receive this specific drug.

If the request is denied, information about the denial will be provided to the provider and the member.

Providers are requested to utilize the PDL when prescribing medication Pennsylvania Health & Wellness members. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included in the Pennsylvania Health & Wellness PDL.

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

**PROVIDER RELATIONS AND SERVICES**

**Provider Relations**

Pennsylvania Health & Wellness’s Provider Relations department is committed to supporting our providers as they care for our members. Through provider orientation, 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 Relations representative. Within 30 days of
the provider’s effective date, the Provider Relations representative will contact the provider to schedule an orientation.

**Reasons to Contact a Provider Relations Representative**

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

**Provider Services**

Provider Services is available at [phone number to be updated by 10/1/16] 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 Pennsylvania 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 Pennsylvania Health & Wellness, as well as government regulations and standards of accrediting bodies.

Pennsylvania 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 Pennsylvania Health & Wellness’ members, 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 Pennsylvania Health & Wellness of any relevant changes to their credentialing information in a timely manner.*

**Which Providers Must be Credentialed?**

All of the following providers are required to be credentialed:

*Medical practitioners*

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

**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 Pennsylvania Health & Wellness:

- A completed, signed and dated Credentialing application
- Providers can authorize Pennsylvania Health & Wellness access to their information on file with the CAQH (Council for Affordable Quality Health Care) [www.CAQH.org](http://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 postgraduate 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)
  o 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 Pennsylvania 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
• Federal and state sanctions and exclusions

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

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, Pennsylvania 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 Pennsylvania Health & Wellness network.

In between credentialing cycles, Pennsylvania 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, Pennsylvania Health & Wellness reviews monthly reports released by the Office of Inspector General and other sources to identify network providers who have been newly sanctioned or excluded from participation in federal and state programs.

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

**Right to Review and Correct Information**

All providers participating within the Pennsylvania 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 Pennsylvania 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 Pennsylvania 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 Pennsylvania 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 [phone number to be updated by 10/1/16]
Right to Appeal Adverse Credentialing Determinations

Pennsylvania 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 Pennsylvania 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. Pennsylvania 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 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

Pennsylvania 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 Pennsylvania Health & Wellness within 30 days of the change. Please contact Pennsylvania Health & Wellness Provider Relations Department at [phone number to be updated by 10/1/16] if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

RIGHTS AND RESPONSIBILITIES

Member Rights

As a member, you have certain rights. Pennsylvania Health & Wellness also expects its providers to respect and honor your rights:

- To be treated with respect and dignity.
- To pick or change doctors from the list of doctors in our Provider Network.
- To be able to get in touch with the Provider.
- To go to any Provider or clinic that provides Family Planning services.
- To get care right away if you have an Emergency Medical Condition.
• To be told what your illness or medical problem is and what your Provider thinks is the best way to treat it.
• To decide about your health care and to give permission before the start of diagnosis, treatment or surgery.
• To have the personal information in medical records kept private.
• To be treated with respect, dignity and privacy.
• To report any complaint or grievance about your Provider or medical care.
• To file an appeal of an action that reduces or denies services based on medical criteria.
• To receive interpretation services
• To be free from being coerced into making decisions about treatment
• To be free from being discriminated against due to race, color, national origin or health status or the need for health care services.
• To have the right to request a second opinion.
• To be notified at the time of enrollment and annually of your disenrollment rights.
• Other member rights and protections, as specified in 42 CFR § 438.100
• To make an advance directive.
• To file any complaint about not following your advance directive with the Pennsylvania Department of Health.
• To choose a provider who gives you care whenever possible and appropriate.
• To receive accessible health care services comparable in amount, duration and scope to those provided under Medicaid FFS and sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished.
• To receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
• Freedom to exercise the rights described herein without any adverse effect on the treatment by Pennsylvania Department of Health, Pennsylvania Health & Wellness, its providers or contractors.
• To receive all written member information from Pennsylvania Health & Wellness:
  o At no cost to you.
• In the prevalent non-English languages of its members in the service area.

• In other ways, to help with the special needs of members who may have trouble reading the information for any reason.

• To receive oral interpretation services free of charge for all non-English languages, not just those identified as “prevalent.”

• To be notified that oral interpretation services are available and how to access them.

• To get help from both Pennsylvania Department of Health and its Enrollment Broker in understanding the requirements and benefits of Pennsylvania Health & Wellness.

**Member Responsibilities**

As a member, you have certain responsibilities:

• A description of procedures to follow if:
  - Your family size changes.
  - You move out of the Region, out-of-state or have other address changes.
  - You obtain or have health coverage under another policy, other third party, or there are changes to that coverage.

• To take actions toward improving your own health, your responsibilities and any other information deemed essential by Pennsylvania Health & Wellness.

• Information about the process that you and your providers must follow when requesting non-emergent inpatient hospitalization Prior Authorization, including how to notify Pennsylvania Health & Wellness of an inpatient admission for non-emergent care.

• Information on any of cost-sharing responsibilities.

• To inform Pennsylvania Health & Wellness of the loss or theft of your member ID card.

• To present your member ID card when using healthcare services.

• To be familiar with Pennsylvania Health & Wellness procedures and coverage rules and restrictions to the best of your abilities.

• To call or contact Pennsylvania Health & Wellness to obtain information and have questions clarified.

• To provide providers with accurate and complete medical information.
• To follow prescribed treatment of care recommended by a provider or letting them know the reason(s) treatment cannot be followed, as soon as possible.

• To ask questions of your providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors.

• To understand your health problems and participate in developing mutually agreed upon treatment goals with your provider to the highest degree possible.

• To follow the Grievance process established by Pennsylvania Health & Wellness (and as outlined in this Member Handbook) if there is a disagreement with a provider.

Provider Rights

Pennsylvania 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 members’ 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 members’ treatment plans

• Expect members to follow their directions

• Make a complaint or file an appeal against Pennsylvania Health & Wellness and/or a member

• File a grievance with Pennsylvania Health & Wellness on behalf of a member, with the member’s consent

• Have access to information about Pennsylvania Health & Wellness quality improvement programs, including program goals, processes, and outcomes that relate to member care and services

• Contact Pennsylvania Health & Wellness Provider Services with any questions, comments, or problems,

• Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

Pennsylvania Health & Wellness providers have the responsibility to:

• Help members or advocate for members 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 members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members’ advance directives and include these documents in the members’ medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can’t fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members’ 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 Pennsylvania Health & Wellness data collection initiatives, such as HEDIS and other contractual or regulatory programs
• Review clinical practice guidelines distributed by Pennsylvania Health & Wellness
• Comply with Pennsylvania Health & Wellness Medical Management program as outlined in this handbook.
• Disclose overpayments or improper payments to Pennsylvania Health & Wellness
• Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status
• Obtain and report to Pennsylvania Health & Wellness information regarding other insurance coverage
• Notify Pennsylvania Health & Wellness in writing if the provider is leaving or closing a practice
• Contact Pennsylvania Health & Wellness to verify member eligibility or coverage for services, if appropriate
• Invite member 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 members, 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 members will be no less than those offered to commercial members
• Not be excluded, penalized, or terminated from participating with Pennsylvania Health & Wellness for having developed or accumulated a substantial number of patients in the Pennsylvania Health & Wellness with high cost medical conditions
• Coordinate and cooperate with other service providers who serve Medicaid members 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 Pennsylvania 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 Pennsylvania 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 RFP

**COMPLAINT AND GRIEVANCE PROCESS**

A member, or member authorized representative, may file a complaint verbally and in writing or grievance (writing only). A provider, acting on behalf of the member and with the member's written consent, may file a complaint or grievance.

Pennsylvania Health and Wellness will give members reasonable assistance in completing all forms and taking other procedural steps of the complaint and grievance system, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.

Pennsylvania Health & Wellness values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a complaint or grievance on a member’s behalf. Pennsylvania Health & Wellness will provide assistance to both members and providers with filing a complaint or grievance by contacting our Member and Provider Services Department at [Phone number to be updated by 10/1/16].

NOTE: Throughout the manual, we will consider the term “complaint” to refer to both member complaints and provider complaints as the resolution processes are the same. Provider complaints include disagreements regarding policies, procedures or any aspect of Pennsylvania Health & Wellness administrative functions.

**Member Complaints**

Pennsylvania Health and Wellness will have a two-level complaint procedure and a two-level grievance procedure. Member complaint is an issue, a member presents to the Plan either written or oral subject to informal resolution by Plan within 30 days.

Pennsylvania Health & Wellness will allow the member at least 45 days to file a complaint or grievance from the date of the occurrence of the issue being complained about, or the date of the member’s receipt of notice of the plan’s decision.

**First Level Complaint Review**

Pennsylvania Health & Wellness shall permit a member or the member’s representative to file a written or oral complaint. That the member or the member’s representative may review information related to the complaint upon request and submit additional material to be considered by the plan.
The first level complaint review shall be performed by an initial review committee which shall include one or more employees of Pennsylvania Health & Wellness. Any individuals who make a decision on complaints will not be involved in any previous level of review or decision making. In any case where the reason for the complaint involves clinical issues or relates to denial of expedited resolution of a grievance, Pennsylvania Health & Wellness shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member’s condition or disease. [42 CFR § 438.406]

Acknowledgement
Staff receiving complaints orally will acknowledge the complaint and attempt to resolve it immediately. Staff will document the substance of the complaint. For informal complaints, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details in the documentation system. The Grievance Coordinator will date stamp written complaints upon initial receipt and send an acknowledgment letter, which includes a description of the complaint procedures and resolution time frames, within five business days of receipt. Member notification of the complaint resolution and instructions on how to file a second level review shall be made in writing within two business days of the resolution.

Second Level Grievance Review
Upon receipt of the request for the second level review, Pennsylvania Health & Wellness will send the member and the member’s representative an explanation of the procedures to be followed during the second level review.

The second level complaint review shall be performed by a second level review committee made up of three or more individuals who did not participate in the matter under review. At least one third of the second level review committee may not be employees of Pennsylvania Health & Wellness or of a related subsidiary or affiliate.

The Second Level Review Committee will issue a formal decision within 45 of the plan’s receipt of the request of the enrollee or the enrollee’s representative for a second level review.

If the member is dissatisfied with the Second Level Review Committee decision, the member can appeal to the Pennsylvania Department of Health.

A member shall have 15 days from receipt of the second level review decision of a complaint to file an appeal of the decision with either the Department of Health or the Insurance Department. The appeal shall be in writing unless the enrollee requests to file the appeal in an alternative format.

Complaint Resolution Time Frame
Complaint Resolution will occur as expeditiously as the member’s health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the complaint. Complaint will be resolved by the Grievance Coordinator, in coordination with other Pennsylvania Health & Wellness staff as needed. In our experience, many complaints can be resolved at the customer service level to the satisfaction of the member, representative or provider filing the complaint.
Notice of Resolution

The Grievance Coordinator will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and Pennsylvania Department of Health appeal requirements.

The complaint response shall include, but not be limited to, a statement of the issue reviewed by the Committee, the decision reached by Pennsylvania 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 member, if any a copy of all verbal and written complaints. Logs and records of disposition or written complaints shall be retained for ten years.

Complaints may be submitted by written notification to:

[Health plan address to be updated by 10/1/16]

Grievances

A member, member’s representative, or health care provider seeking to file a grievance with member consent will have the same time frames in which to file as a member complaint.

A Grievance is a request to review a denial of coverage for a health care service on the basis of medical necessity and appropriateness or review of a “Notice of Adverse Action.” A “Notice of Adverse Action” is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; failure to cover or provide services in a timely manner, Pennsylvania; failure to process the complaint, grievance, , or expedited grievance within required timeframes; or the denial of a member’s request to exercise his/her right under 42 CFR 438.52(b)(ii) to obtain services outside Pennsylvania Health & Wellness network.

Both the initial and second level grievance review shall include a licensed physician or an approved licensed psychologist, in the same or similar specialty as that which would typically manage or consult on the health care service in question.

For all levels of a grievance review process, Pennsylvania Health & Wellness will advise the member of the right to request continuation of benefits as set forth in the Member Grievance System Description while the grievance is pending and that the member may in such a case be held liable for the cost of those benefits if the appeal is not decided in favor of member.

Acknowledgement

The Grievance Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt. Member notification of the grievance resolution and instructions on how to file a second level review shall be made in writing.
First Level Review
The member or the member’s representative, or a health care provider with written consent of the enrollee, may file a written grievance with the plan.

The first level grievance review shall be performed by an initial review committee which shall include one or more individuals selected by the Pennsylvania Health and Wellness. The members of the committee may not have been involved in any prior decision relating to the grievance. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of a grievance, Pennsylvania Health & Wellness shall ensure that the decision makers are health care professionals with the appropriate clinical expertise, same or similar specialty, in treating the member’s condition or disease. [42 CFR § 438.406].

Grievance Resolution Time Frame
Grievance Resolution will occur as expeditiously as the member’s health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the Grievance.

Notice of Resolution
The Grievance Coordinator will provide written resolution to the member, representative or provider within the timeframes noted above. The letter will include the resolution and Pennsylvania Department of Health appeal requirements.

Pennsylvania Health & Wellness shall notify the member, the member’s representative, and the health care provider if the health care provider filed a grievance with member consent, of the decision of the internal review committee in writing, within 5 business days of the committee’s decision.

The notice to the member, the member’s representative, and the health care provider, shall include the basis for the decision and the procedures for the member or provider to file a request for a second level review of the decision of the initial review committee including: 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 member, if any.

A copy of all grievances logs and records of disposition or written grievances shall be retained for ten years.

An explanation of how to file a request for a second level review of the decision of the initial review committee and the time frames for requesting a second level review, if any grievances may be submitted by written notification to:

[Health plan address to be updated by 10/1/16]
Second Level Review

Upon receipt of the request for the second level review, Pennsylvania Health & Wellness will send the member and the member’s representative an explanation of the procedures to be followed during the second level review.

The second level complaint review shall be performed by a second level review committee made up of three or more individuals who did not participate in the matter under review. At least one third of the second level review committee may not be employees of Pennsylvania Health & Wellness or of a related subsidiary or affiliate.

The Second Level Review Committee will issues a formal decision within 45 of the plan’s receipt of the request of the enrollee or the enrollee’s representative for a second level review.

If the member is dissatisfied with the Second Level Review Committee decision, the member can request an external grievance review.

Expedited Grievances

A member has the right to request an expedited grievance review at any stage of the grievance review process. Expedited grievances may be filed when Pennsylvania Health & Wellness or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited grievances are issued as expeditiously as the member’s health condition requires, not exceeding 48 hours from the initial receipt of the request for an expedited grievance review.

Written notice shall include the following information:

- The decision reached by Pennsylvania Health & Wellness;
- The date of decision;
- For grievances not resolved wholly in favor of the member the right to request a further review and information as to how to do so; and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Pennsylvania Health & Wellness decision.
- If the action taken by the Plan is upheld on grievance review, the member may be liable for the cost of any continued benefits
Call or mail all grievance review requests to:

Pennsylvania Health & Wellness
[Health plan address to be updated by 10/1/16]

External Grievance Process

Pennsylvania Health & Wellness will establish and maintain an external grievance process by which a member, or a health care provider with the written consent of the member, may request an external review of a denial of a second level grievance following receipt of the second level grievance review decision.

Any second level grievance review that is not resolved wholly in favor of the member by Pennsylvania Health & Wellness may be appealed by the member or the member’s authorized representative to an External Review Entity for a hearing conducted in accordance with 42 CFR § 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials.

A member, the member’s representative or the health care provider who filed the grievance shall have 15 days from receipt of the second level grievance review decision to file a request for an external review with the plan.

The assigned External Review Entity shall review and issue a written decision within 60 days of the filing of the request for an external grievance review. The decision shall be sent to the member and the member’s representative, the health care provider, if the health care provider filed the grievance with member consent, the plan, and the Department of Health. The decision shall include 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 member, and the member’s representative, or the health care provider have 60 days from receipt of the decision to appeal to a court of competent jurisdiction.

Pennsylvania Health & Wellness shall comply with the External Review Entity’s decision.

Reversed Grievance Resolution

In accordance with 42 CFR §438.424, if Pennsylvania 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, Pennsylvania Health & Wellness will authorize the disputed services promptly and as expeditiously as the member’s health condition requires. Additionally, in the event that services were continued while the appeal was pending, Pennsylvania Health & Wellness will provide 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 External Grievance Review:
WASTE, FRAUD AND ABUSE

Pennsylvania 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. Pennsylvania Health & Wellness, successfully operates a Special Investigations Unit (SIU). Pennsylvania Health & Wellness operates a Special Investigations Unit (SIU). It 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 section of this handbook. Pennsylvania 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
- Any other remedies available to rectify

Pennsylvania 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

Pennsylvania 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 Pennsylvania Health & Wellness members. 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,

Pending Commonwealth Approval
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 members’ 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.

**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, Pennsylvania Health & Wellness Auditors request medical records for a defined review period. Providers have two weeks 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, Pennsylvania Health & Wellness will recover all amounts paid for the services in question.

Pennsylvania 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 member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

Pennsylvania 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, Pennsylvania Health & Wellness will seek recovery of all overpayments. Depending on the number of services provided during the review period, Pennsylvania 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.)

Pending Commonwealth Approval
58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Pennsylvania 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 Pennsylvania Program Integrity Department and may also be reported to the Pennsylvania Healthcare Fraud Control Unit.

**Suspected Inappropriate Billing**

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Pennsylvania 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, Pennsylvania 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.

**QUALITY IMPROVEMENT**

Pennsylvania Health & Wellness culture, systems and processes are structured around its mission to improve the health of all enrolled members. 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 members, including those with special needs.

This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and 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.

Pennsylvania Health & Wellness recognizes its legal and ethical obligation to provide members 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 its members.

Where the member’s condition is not amenable to improvement, Pennsylvania 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 member. This will include the
identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions.

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

Program Structure

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

The Quality Improvement Committee (QIC) is a senior management committee with 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 members. 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 member outcomes, and the education of members, providers and staff regarding the QI and Medical Management programs.

The following sub-committees report directly to the Quality Improvement Committee:

- Utilization Management Committee
- Credentialing Committee
- Performance Improvement Team
- HEDIS Steering Committee
- Joint Operations Committees
- Therapeutics Committee
- Peer Review Committee (Ad Hoc Committee)

Practitioner Involvement

Pennsylvania Health & Wellness recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Pennsylvania Health & Wellness encourages PCP, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC and select ad-hoc committees.
Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Pennsylvania Health & Wellness members. Pennsylvania 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, and ancillary services, and operations.

Pennsylvania Health & Wellness primary QAPI Program goal is to improve members’ 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.

To that end, the Pennsylvania Health & Wellness QAPI Program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Delegated entity oversight
- Continuity and coordination of care
- Medical Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member experience
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- Department performance and service
- Patient safety
- Marketing practices
Patient Safety and Quality of Care

Patient Safety is a key focus of Pennsylvania 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 member.

Pennsylvania Health & Wellness employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require 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

Pennsylvania Health & Wellness QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional 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 health outcomes or the service.

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 QI initiative is also designed to allow Pennsylvania Health & Wellness to monitor improvement over time.

Annually, Pennsylvania 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 QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.
Pennsylvania Health & Wellness communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Pennsylvania Health & Wellness web portal at PAHealthWellness.com.

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

**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 as well. 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 members. 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’ and ‘quality bonus funds’. 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 typically calculated using administrative data 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, to name a few measures.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but 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 Pennsylvania 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: childhood immunizations, well child visits, diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.
When Will the Medical Record Reviews (MRR) Occur for HEDIS?

Pennsylvania Health & Wellness may contract with a national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative 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 member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Pennsylvania 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 related to HEDIS measures such as, body mass index (BMI) calculations, eye exam results and blood pressure readings.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at [Phone number to be updated by 10/1/16].

MEDICAL RECORDS REVIEW

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

Pennsylvania Health & Wellness requires providers to maintain all records for members for at least ten years. See the Member Rights section of this handbook for policies on member access to medical records. Pennsylvania Health & Wellness may conduct medical record reviews for the purposes including but not limited to utilization review, quality management, medical claim review, or member complaint/appeal investigation. Physicians must meet 80% of the requirements for medical record

Pending Commonwealth Approval
keeping; elements scoring below 80% are considered deficient and in need of improvement. The Applicant will work with any physician who scores less than 80% to develop an action Applicant 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 means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or provider, that document all medical services received by the member, 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 members in accordance with the following standards:

- Member’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 up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Pennsylvania Health & Wellness’ practice guidelines.
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters;
- For children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- 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 member.
• 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.
• For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members 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 member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
• Confidentiality of member information and records protected.
• Evidence that an advance directive has been offered to adults 18 years of age and older.

**Medical Records Release**

All member 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 member/patient. The MRR vendor will sign a HIPAA compliant
Business Associate Agreement with Pennsylvania Health & Wellness which allows them to collect PHI on our behalf.

**Medical Records Transfer for New Members**

All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned Pennsylvania Health & Wellness members. If the member or member’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.