

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE**

**OFFICE OF DEVELOPMENTAL PROGRAMS  
BUREAU OF AUTISM SERVICES**

**AGREEMENT for the  
ADULT COMMUNITY AUTISM PROGRAM (ACAP)**

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This Agreement is entered into between the **Commonwealth of Pennsylvania Department of Public Welfare** (hereinafter the Department), and **Keystone Autism Services**, a wholly owned subsidiary of Keystone Human Services, Inc.(hereinafter the Contractor), with a principal place of business located at 124 Pine Street, Harrisburg, Pennsylvania 17101 and is effective February 18, 2009.

WHEREAS, the Pennsylvania Medical Assistance Program is authorized by Title XIX of the Social Security Act, 42 U.S.C. A. §§ 1396 – 1396v, and the Public Welfare Code, 62 P.S. §§ 101 – 1503, to provide payment for medical services to persons eligible for Medical Assistance; and

WHEREAS, Federal regulations at 42 CFR Chapter 438 authorize delivery of Medical Assistance services through a Prepaid Inpatient Health Plan (PIHP); and

WHEREAS, the Department has determined to develop a PIHP for delivery of a comprehensive set of services to Medical Assistance recipients twenty-one (21) years of age or older with Autism Spectrum Disorder (ASD) focused on the unique needs of this population; and

**WHEREAS**, the Department has determined that the Contractor understands the needs of Medical Assistance recipients twenty-one (21) years of age or older with ASD and can provide or arrange for services and coordinate and manage the services provided to this population;

NOW, THEREFORE, in consideration of the mutual promises contained herein and intending to be legally bound, the Contractor and the Department hereby agree as follows:

#### **ARTICLE I: DEFINITIONS**

As used in this Agreement, each of the following terms shall have the specified meanings unless the context clearly indicates otherwise.

**1.1 ACAP** shall mean the Adult Community Autism Program.

**1.2 Advance Directive** shall mean a written instruction such as a living will or a health care power of attorney, which either allows another individual to make health care decisions for a Participant or expresses a Participant's wishes and instructions for health care and health care

directions when the Participant is determined to be incompetent and has an end-stage medical condition or is permanently unconscious.

- 1.3 **Applicant** shall mean a person seeking enrollment in ACAP.
- 1.4 **Authorized Services** shall mean the Covered Services the Contractor has approved for payment.
- 1.5 **Autism Spectrum Disorder (ASD)** shall mean a condition having one of more of the following ICD-9 codes:
  - A. 299.00 Autistic Disorder
  - B. 299.10 Childhood Disintegrative Disorder
  - C. 299.80 Pervasive Developmental Disability, not otherwise specified; Asperger Disorder; Rett Disorder
- 1.6 **BAS** shall mean the Bureau of Autism Services.
- 1.7 **Behavioral Support Plan** shall mean a plan developed by a Behavioral Health Practitioner or a Behavioral Health Specialist that includes a set of interventions to be used by people who interact with the Participant on a regular basis, intended to increase and improve the Participant's adaptive behaviors.
- 1.8 **Capitation Services** shall mean those services listed in Section 2.1 of this Agreement, for which the Contractor receives a Capitation Payment from the Department.
- 1.9 **Capitation Payment** shall mean the monthly payment issued to the Contractor by the Department, in return for which the Contractor accepts risk for providing Capitation Services and the responsibility for fulfilling the terms of this Agreement.
- 1.10 **Capitation Rate** shall mean the rate, established by the Department, at which the Capitation Payment is made.
- 1.11 **CMS** shall mean the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.
- 1.12 **Complaint** shall mean a dispute or objection regarding a Provider or the operations or management policies of the Contractor, which has not been

resolved by the Contractor and has been filed with the Contractor, including but not limited to:

- A. The denial of a service/item because the requested service/item is not a Covered Service; or
- B. The failure of the Contractor to meet the required timeframes for providing a service/item; or
- C. The failure of the Contractor to decide a Complaint or Grievance within the specified timeframes; or
- D. The denial of payment by the Contractor after a service/item has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or
- E. The denial of payment by the Contractor after a service/item has been delivered because the service/item provided is not an Authorized Service/Item for the Participant; or
- F. The decision to involuntarily disenroll the Participant from the Plan.

The term does not include a Grievance.

**1.13 Covered Services** shall mean Capitation Services and those services that the Contractor has opted to provide as specified in Section 2.3.B.

**1.14 Emergency Medical Condition** shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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, serious impairment to a bodily function, or serious dysfunction of any bodily organ or part.

**1.15 Emergency Services** shall mean medical care rendered in an inpatient or outpatient setting that is furnished by a provider who is qualified to furnish those services and that is needed to evaluate or stabilize an Emergency Medical Condition.

- 1.16 Functional Behavioral Assessment Based ISP (FBA-Based ISP)** shall mean the ISP developed by the Participant's Team after a functional behavioral assessment of the Participant has been completed.
- 1.17 Grievance** shall mean a request to have the Contractor reconsider a decision solely concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding the Contractor's decision to
- A. Deny, in whole or in part, payment for a service/item;
  - B. Deny or issue an authorization of a requested service/item, including the type or level of service/item in an amount, duration, or scope different from what was requested;
  - C. Reduce, suspend, or terminate a previously authorized service/item; and
  - D. Deny the requested service/item but approve an alternative service/item.

The term does not include a Complaint.

- 1.18 Individual Service Plan (ISP)** shall mean a plan developed by the Participant's Team that specifies the services a Participant will receive, the reason(s) those services are needed, and the goals and objectives of the services.
- 1.19 Initial ISP** shall mean the ISP developed by the Participant's Team but before a functional behavioral assessment is completed.
- 1.20 Institution for Mental Diseases (IMD)** shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services.
- 1.21 Medical Assistance** shall mean the Medical Assistance Program administered by the Department as authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396v, and the Public Welfare Code, 62 P.S. §§ 101 - 1503, and regulations promulgated thereunder.
- 1.22 Medically Necessary** shall mean that a service, item, procedure, or level of care meets one of the following standards:

- A. The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- B. The service, item, procedure, or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability.
- C. The service, item, procedure, or level of care will assist the Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.

**1.23 Network** shall mean the group of Providers that have a written agreement with the Contractor that a Participant may choose from to receive Authorized Services.

**1.24 Network Provider** shall mean a Provider that has a written agreement with the Contractor to provide services to a Participant and participates in the Network.

**1.25 Non-Capitation Services** shall mean Covered Services that are not included in the Capitation Payment and which the Contractor is not required to provide.

**1.26 Non-Network Provider** shall mean a Provider that does not participate in the Network and that provides services to a Participant..

**1.27 Participant** shall mean a person who is enrolled in ACAP.

**1.28 Participant Liability** shall mean the total dollar amount of incurred medical expenses in an institutional setting that a Participant is responsible to contribute toward the monthly Capitation Payment, as determined by the Department or, for Participants receiving Residential Support, the total dollar amount that the Participant is responsible to contribute to the cost of room and board.

**1.29 Plan** shall mean the program through which the Contractor provides or arranges for the delivery of ACAP services as required by this Agreement.



- 1.30 Post-Stabilization Care Services** shall mean Covered Services related to an emergency medical condition or crisis intervention that are provided after a Participant is stabilized in order to maintain the stabilized condition, or to improve or resolve the Participant's condition.
- 1.31 Primary Care Provider (PCP)** shall mean a physician, nurse practitioner, or physician assistant who is responsible for coordinating a Participant's health care needs and initiating and monitoring referrals for specialized medical services when required.
- 1.32 Provider** shall mean a person, firm, or corporation that may or may not be a member of the Network but has an agreement with the Contractor to deliver services to a Participant.
- 1.33 Restraint** shall mean any physical, chemical, or mechanical intervention that restricts the movement or function of a Participant or a portion of a Participant's body.
- 1.34 Seclusion** shall mean the involuntary confinement of a Participant alone in a room or an area from which the Participant is physically prevented from having contact with others or leaving.
- 1.35 Service Area** shall mean the geographic area as established by the Department within which a Participant must reside in order to participate in the Plan.

## **ARTICLE II: SERVICE PROVISION**

### **2.1 Functions and Duties of the Contractor**

The Contractor shall:

- A. Provide or arrange for the delivery of all Authorized Services to each Participant for the term of the Participant's enrollment.
- B. Conduct assessments using the instruments and at the frequency specified in Appendix A.
- C. Maintain a record for each Participant and require its Providers to maintain a record for each Participant.

1. The record maintained by each Provider must document all care provided and comply with the requirements specified in the Department's Medical Assistance regulations that are appropriate to the standard of care for that Provider.
2. The Contractor's record for each Participant must include, at a minimum, the following:
  - a. Identification of the Participant on each page
  - b. Identifying demographic information
  - c. A complete medical history
  - d. The Participant's complaints accompanied by the Contractor's findings
  - e. A preliminary working diagnosis as well as a final diagnosis based on the Participant's history and examination
  - f. Documentation of all services provided, including documentation of the medical necessity of a rendered, ordered, or prescribed service
  - g. Multi-disciplinary assessments, reassessments, plans of care, treatment and progress notes
  - h. Drugs prescribed as part of the treatment, including the quantities and dosage, and if the prescription was telephoned to a pharmacist
  - i. Lab reports, including interpretations of diagnostic tests and reports of consultations
  - j. Hospital discharge records
  - k. Reports from the Contractor and Providers
  - l. Contacts with informal supports (Participant's family, friends, church, etc.)

- m. The Participant's signed Enrollment Agreement and signed statement verifying the Participant's or, if appropriate, the Participant's representative's, review and receipt of the Participant Handbook
  - n. Physician orders
  - o. The Participant's Initial ISP and FBA-Based ISP, including the Crisis Intervention Plan, Behavioral Support Plan, and medication therapeutic management plan, and all updates and revisions.
  - p. The disposition of the case
- 3. The record shall be legible throughout and entries shall be signed and dated by the responsible Provider. Care rendered by ancillary personnel shall be countersigned by the responsible Provider. Alterations of the record shall be signed and dated.
- D. Maintain an after-hours call-in system to provide prompt and easy access, twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year, to Covered Services when medically necessary.
- E. Ensure that a physician and Behavioral Health Specialist are on call to provide prompt, professional consultation to Participants twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year.
- F. Provide prompt access to Habilitation and Supports Coordination services using Contractor's staff and to all other services using either Contractor's staff or Providers.
- G. Develop and maintain a Network sufficient to provide prompt access to Covered Services that are not required to be delivered directly by the Contractor. During the first six (6) months after BAS begins to accept inquiries about enrollment in the Plan, the Contractor must offer Participants a choice of at least two (2) Network Providers in the following disciplines: Primary care (including family practitioners and general internists), psychiatry, neurology, gynecology, urology, gastroenterology, endocrinology, dentistry, and optometry; and one (1) Network Provider for all other

disciplines. Thereafter the Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. The Contractor shall enter into written agreements with all Providers as specified in Section 2.5.

- H. Demonstrate to the Department, and provide supporting documentation, that it has the capacity to serve the expected enrollment in the Service Area in accordance with the requirements in this Agreement by:
  - 1. Maintaining an updated list of all Provider subcontracts that includes Provider name, address, phone number, services provided under the subcontract, subcontract expiration date, and whether or not the subcontract is automatically renewable.
  - 2. Submitting a list of all subcontracts with Providers to the Department at the time the Contractor enters into this Agreement and upon request.
  - 3. Submitting an updated list of Network Provider subcontracts within two days of the Contractor's knowledge of a change that would affect capacity and services.
- I. Require Network Providers to offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to the hours offered for individuals who receive Medical Assistance services in the fee-for-service delivery system, if the Network Provider serves only Medical Assistance patients.
- J. Ensure that every Participant has an assigned Primary Care Provider (PCP). Unless it would be to the Participant's benefit, the PCP must participate in the Contractor's Network. The assigned PCP may be a specialist, if the needs of a Participant warrant. The Contractor must offer each Participant a choice of at least two (2) PCPs. If a Participant fails to choose a PCP within fourteen (14) days of enrollment in the Plan, the Contractor must assign a PCP to the Participant. In assigning PCPs, the Contractor must consider current Provider-Participant relationships, special medical needs, area of residence, language and other needs, and access to transportation. The Contractor must have written procedures and policies for allowing the Participant to change his or her PCP.

These procedures must receive advance written approval from the BAS.

- K. Respond, report, and follow up on all incidents as specified in Appendix B.
- L. Assign a Team to each Participant, which is responsible for assessment, service planning, care delivery and managing delivery of services, quality of services, and continuity of care.
  - 1. The Team shall include at a minimum:
    - a. The Participant and the Participant's guardian, if the Participant has a guardian, and his or her family consistent with the Participant's or guardian's wishes.
    - b. A Behavioral Health Specialist
    - c. A Supports Coordinator

Other disciplines that must be available to the Team either in person or by phone or become members of the Team as needed include a physician, nurse, physical and occupational therapists, dietitian, and ancillary staff engaged in Participant diagnosis and treatment or who are responsible for the initiation, provision, coordination, or evaluation of care and services provided to the Participant. BAS must also be allowed to participate in Team meetings if BAS has notified the Contractor that it wants to participate in the Team meetings. Team members shall not change except as necessary to meet the needs of the Participant.

- 2. The Team is responsible for developing an Initial ISP within fourteen (14) days of being notified by BAS that an Applicant is eligible for enrollment in the Plan. The timeframe for developing the Initial ISP may be extended for circumstances beyond the Contractor's control with prior approval from BAS.
- 3. The Team is responsible for developing an FBA-Based ISP that is consistent with and supports the functional behavioral assessment, and which includes a Behavioral

Support Plan, a Crisis Intervention Plan, and a medication therapeutic management plan within sixty (60) days of enrollment. The time frame for completing the FBA-Based ISP may be extended for circumstances beyond the Contractor's control with prior approval from BAS. The FBA-Based ISP must be reviewed at least every three (3) months and after each episode that triggers implementation of the Crisis Intervention Plan or the use of a Restraint and must be reassessed and updated at least annually. Monitoring and annual reassessments must address the Participant's progress toward more inclusive and less restrictive services than were provided the previous year.

4. The Team must use a Person-Centered Planning process in developing the Initial ISP and in developing, reviewing, and updating or revising the FBA-Based ISP. The Person-Centered Planning process must include:
  - a. Understanding the Participant's needs and desires in the present and future;
  - b. Identifying the services and other supports the Participant will need to meet his or her needs and desires; and
  - c. Determining what steps need to be taken to meet the Participant's needs and desires.
5. The Initial ISP and the FBA-Based ISP must include the Covered Services agreed to by the Team, and any other services and informal supports that complement the Covered Services that will be furnished to or coordinated for the Participant; which services the Contractor will pay for, the projected amount, frequency, and duration of services; the justification for each service; and the goals, objectives, and expected outcomes of the plan. In order to be authorized, Covered Services must be Medically Necessary; meet the Participant's needs in the most inclusive, cost-effective, and least-restrictive manner appropriate for the Participant's needs; and build on the Participant's strengths to improve social skills and self-management in ways that increase independence and participation in community life. Documentation must be included in the Initial ISP and the

FBA-Based ISP that describes the decision-making process and how the services meet this requirement.

6. The Behavioral Support Plan and the Crisis Intervention Plan must be developed by either a Behavioral Health Practitioner or a Behavioral Health Specialist and be based on a functional behavioral assessment conducted in accordance with the guidelines provided in *Functional Assessment and Program Development for Problem Behavior - A Practical Handbook* (2d ed.), by Robert O'Neill, Robert Horner, Richard Albin, Jeffrey Sprague, Keith Storey, and Stephen Newton. In order to adapt this handbook for adults, references to "student" are to be read as "adult" and references to "school" or "school day" are to be read as "activities during the Participant's day." The functional behavioral assessment must include a medication review by a Doctor of Pharmacy if it is recommended by any member of the Team or if four (4) or more psychotropic medications are prescribed for the Participant.
  
7. The Behavioral Support Plan must be outlined as a guide to be used by people who interact with the Participant on a regular basis and include the following:
  - a. A set of interventions intended to
    - i) modify the environment to eliminate potential triggers of problem behavior,
    - ii) modify responses to problem behavior to increase appropriate behavior and decrease problem behavior, and
    - iii) increase and improve the Participant's adaptive behaviors.
  
  - b. Whether Restraint may be used and, if so, the type of Restraint that may be used, the circumstances under which the Restraint may be used, and why other less restrictive methods would be unsuccessful in protecting the participant from injuring himself or herself or others; the amount of time the Restraint

- may be applied; any physical problems that require special attention during the use of the Restraint; who will be trained on the use of the Restraint; and who will provide and document the training on the use of the Restraint.
- c. For every Participant who is on medication, an ongoing medication therapeutic management plan that includes the input of a Doctor of Pharmacy, if recommended by any member of the Team or if four (4) or more psychotropic medications are prescribed for the Participant
  - d. A description of how the effectiveness of the plan and its implementation in supporting the Participant will be monitored and evaluated on a regular basis and after each Crisis Event.
8. The Crisis Intervention Plan must identify how crisis intervention services will be available to the Participant, how the Contractor's staff and Providers will be kept informed of precursors to the Participant's challenging behavior, and the procedures and interventions that are most effective to deescalate the challenging behaviors. (See Appendix C for the required components of a Crisis Intervention Plan.)
- M. Develop and implement procedures to coordinate the Authorized Services provided to a Participant with services he or she receives outside of the Plan and inform all Providers as necessary of the Participant's needs as identified by the Contractor and the Authorized Services delivered to the Participant to prevent duplication of activities. The procedures must ensure that each Participant's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable.
  - N. Ensure that the Authorized Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
  - O. Ensure that Authorized Services are delivered promptly and consistent with the needs of the Participant and ensure that PCP and specialist visits are scheduled in a timely manner. Urgent



medical or behavioral condition cases must be scheduled by the Contractor with the PCP or the Behavioral Health Specialist to take place within twenty-four (24) hours of the request for an appointment and with other specialists to take place within twenty-four (24) hours of referral. Routine appointments must be scheduled by the Contractor with the PCP to take place within seven (7) days of the request for an appointment and with the specialist to take place within seven (7) days of referral. Unless the Participant had a complete physical examination within three (3) months before enrolling in the Plan and the Team agrees that an examination is unnecessary, a general physical examination, including a vision test, must be conducted by the PCP within three (3) weeks of enrollment and annually thereafter, except that during the first three (3) months after the first Participant is enrolled in the Plan, a general physical examination, including a vision test, must be conducted by the PCP within three (3) months and three (3) weeks of enrollment and annually thereafter.

- P. If the Contractor cannot directly or through Network Providers provide a Medically Necessary Covered Service to a Participant, the Contractor must provide or arrange for the provision of the service out of network for as long as the Contractor is unable to provide the service, without additional cost to the Participant. The Contractor must enter into a written agreement with each Non-Network Provider.
- Q. Develop and maintain policies and procedures regarding ongoing Participant education. The policies and procedures must be submitted to the Department within fifteen (15) days of the date the Contractor receives the Department's request to review the policies and procedures. Participant education must include the following topics:
1. Capitation Services and other Covered Services, including crisis intervention services, how to access services, and the need to obtain such services from Providers approved by the Contractor;
  2. Services that require a referral and how to obtain a referral;
  3. Complaint, Grievance, and DPW Fair Hearing procedures;
  4. Use of the after-hours call-in system;

5. Self-management of medical problems and behavioral problems;
  6. Disease prevention;
  7. Participant rights and responsibilities, as specified in Section 4.2; and
  8. Written information on advanced directives, as specified in Section 2.5 M.
- R. Provide the following Capitation Services in an amount, duration, and scope that is no less than the amount, duration, and scope of services provided to Medical Assistance recipients who receive their services through the fee-for-service system:
1. All physician services (including Emergency Services provided by a physician, psychiatric services, and direct access to a women's health specialist to provide women's routine and preventative health care services, which is in addition to the Participant's PCP if the PCP is not a women's health specialist)
  2. Certified registered nurse practitioner services
  3. Intermediate Care Facility (ICF) services
  4. Nursing facility services
  5. Non-Emergency medical transportation to services covered under the Medical Assistance Program
  6. Optometrists' services
  7. Chiropractors' services
  8. Audiologists' services
  9. Dentists' services
  10. Podiatrists' services

11. Health promotion and disease prevention services
12. Medical supplies and durable medical equipment
13. Prosthetic eyes and other eye appliances
14. Hospice services
15. Mental health crisis intervention services
16. Outpatient psychiatric clinic services
17. Respiratory services
18. Targeted Case Management
19. Other Capitated services:
  - a. Non-medical transportation
  - b. Supports Coordination
  - c. Visiting nurses
  - d. Physical, occupational, vision and mobility, and speech therapies (group and individual)
  - e. Adult day habilitation services
  - f. Homemaker/Chore services
  - g. Personal Assistance services
  - h. Residential support
  - i. Behavioral support
  - j. Crisis intervention services
  - k. Pre-vocational services
  - l. Respite

- m. Habilitation
- n. Supported employment
- o. Community transition services
- p. Environmental modifications
- q. Assistive technology
- r. Family counseling

These services are defined in the Department's regulations or in Appendix D.

- S. Provide or arrange for the provision of all Medically Necessary counseling or referral services, unless the Contractor objects to the service on moral or religious grounds.

If the Contractor objects to providing or arranging for the provision of counseling or referral services on moral or religious grounds, it must inform the Department of its objection prior to signing the Agreement and inform Applicants prior to enrollment that it does not provide or arrange for the provision of counseling or referral services to which it objects.

If the Contractor determines during the term of this Agreement that it objects to providing or arranging for the provision of counseling or referral services on moral or religious grounds, it must so inform the Department sixty (60) days and all Participants thirty (30) days prior to adopting the policy of not providing or arranging for the provision of counseling or referral services.

- T. Provide the Participant with the opportunity to seek a second opinion from a qualified health care professional within the Network, if available, and if not available, arrange for the Participant to obtain a second opinion from a qualified health care professional outside of the Network, at no cost to the Participant.
- U. Establish performance standards and incorporate them in the Contractor's policies and procedures. The performance standards must be based on the Protocol described in Section 2.5.D and applicable licensing and certification criteria for the services

provided by the Contractor and its Providers.

- V. Ensure that the Contractor's staff and Network Providers:
1. Demonstrate competence to deliver the services they are to provide to a Participant;
  2. Are appropriately trained and oriented to work with persons with ASD and co-occurring diagnoses prior to contact with Participants. Training and orientation include at a minimum: provider training developed by the Department (see Appendix E), CPR, and crisis prevention and intervention including training on Seclusion and Restraint consistent with the requirements in Section 2.2.
- W. Pay for Emergency Services that are Covered Services obtained within or outside the Network whether or not pre-approved by the Contractor, until the attending physician or other provider treating the Participant determines that the Participant is sufficiently stabilized for transfer or discharge.

The Contractor may not do the following:

1. Limit what constitutes an Emergency Medical Condition based exclusively on diagnosis or symptoms.
2. Hold a Participant who has an Emergency Medical Condition liable for payment for services needed to diagnosis the specific condition or stabilize the Participant.
3. Deny payment for Emergency Services that are Covered Services to a Participant who presented with what appeared to be an Emergency Medical Condition but was ultimately determined not to be, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.
4. Deny payment for Emergency Services that are Covered Services to a Participant whom a Contractor's representative instructed to seek Emergency Services.

- X. Pay for Post-Stabilization Care Services obtained within or outside the Network whether or not pre-approved by the Contractor, and charge a Participant no more for Post-Stabilization Care Services delivered by a Non-Network Provider than what the Contractor would charge the Participant if the Participant had obtained the services through the Contractor, if:
1. The Contractor does not respond to a request for pre-approval of Post-Stabilization Care Services within one hour of receiving the request; or
  2. The Contractor cannot be contacted; or
  3. The Contractor's representative and the treating physician cannot reach agreement concerning the Participant's care, and the Contractor's physician is not available for consultation, until the Contractor's physician is reached or:
    - a. A Network physician with privileges at the treating hospital assumes responsibility for the Participant's care;
    - b. A Network physician assumes responsibility for the Participant's care through transfer;
    - c. The Contractor's representative and the treating physician reach agreement concerning the Participant's care; or
    - d. The Participant is discharged.
- Y. Establish practice guidelines to govern the authorization and delivery of services, which are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, consider the needs of the Participants, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate. Practice guidelines must be approved by the Department before being implemented. Guidelines must be shared with all affected Providers and, upon request, with Participants and Applicants. Decisions regarding utilization management; Participant education; coverage of services; information provided to the

Participant and, if appropriate, the Participant's representative concerning the Participant's diagnosis and treatment options; and other areas to which the guidelines apply must be consistent with the guidelines.

- Z. Ensure that the care and services required under this Agreement are provided and administered in accordance with accepted medical or behavioral health practices and professional standards.
- AA. Establish, implement, and maintain documented procedures to manage natural disasters in the Service Area. These procedures must include initial and ongoing training for Contractor staff, Providers, and Participants on what to do, where to go, and whom to contact in case of a natural disaster to ensure Participant safety and continuity of care.
- BB. Provide advance notice to the Department, no later than ten (10) days prior to any action by the Contractor that will impact the Contractor's ability to provide services, including changes in the Network, services, benefits, Service Area, payment rates, or enrollment of a new population in the Plan. The notice must include a transition plan for all affected Participants
- CC. Maintain policies and procedures which address responsibility for scheduling and facilitating Team meetings; handling and resolving Team conflicts; and how Team members will be kept informed of the Participant's behavioral and health status. The policies and procedures must ensure effective communication, input, and interaction among members of the Team and Providers to continuously monitor and take appropriate corrective action concerning the Participant's health status, psycho-social condition, and effectiveness of the Initial ISP and FBA-Based ISP, through observation, direct provision of services, and informal observation, including input from the Participant and persons who interact with the Participant on a regular basis.
- DD. Not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Participant who is his or her patient for the following:
  - 1. The Participant's health status, medical care, behavioral health care, or treatment options, including any alternative treatment that may be self-administered.

2. Any information the Participant needs in order to decide among available treatment and service options.
  3. The risks, benefits, and consequences of treatment or services and non-treatment or non-receipt of services.
  4. The Participant's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- EE. Participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Participants, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- FF. Notify BAS and the appropriate County Assistance Office (CAO), in accordance with current Departmental procedures, when a Participant enters an Institution for Mental Diseases (IMD), ICF or Nursing Facility on a short-term or permanent basis, and when the Participant returns to the community.
- GG. Consult with BAS to confirm that a Participant has been admitted to a facility that is an IMD.
- HH. If a Participant is admitted to an IMD, monitor the Participant's status and update BAS at least weekly or more often as requested by BAS and work with IMD staff and BAS to develop a discharge plan if the Participant will continue to be enrolled in ACAP after discharge.
- II. Notify the CAO upon a Participant's death or disenrollment.
- JJ. Notify BAS upon a Participant's death.

## **2.2 Seclusion and Restraint**

- A. The Contractor shall develop Seclusion and Restraint policies and procedures as specified in this Section.



- B. The Contractor shall ensure that its staff and Providers do not use Seclusion for any reason.
- C. The Contractor shall ensure that its staff and Providers do not use a prone Restraint for any reason.
- D. The Contractor shall ensure that its staff and Providers use only clinically approved Restraints and receive training on the appropriate use of these Restraints.
- E. The Contractor shall ensure that its staff and Providers do the following:
  - 1. Try all less intrusive alternatives to de-escalate a Participant's Behavior prior to using a Restraint.
  - 2. Use a Restraint only as a last resort and only to control acute episodic behavior that poses a threat to a Participant or others, to protect a Participant's health or safety, or to protect the health and safety of others.
  - 3. Consider a Participant's medical and behavioral health history prior to using a Restraint.
  - 4. Use only the type of Restraint identified in the Behavioral Support Plan and change the position of the Restraint at least every ten (10) minutes.
  - 5. When a Restraint is used, continuously observe the physical and emotional condition of the Participant and document the observations at least every ten (10) minutes in the Participant's record.
  - 6. Immediately release a Participant from a Restraint as soon as it is determined that the Participant is no longer a threat to himself or herself or to others, which may not exceed thirty (30) minutes in a two (2) hour period.
  - 7. When a Restraint is used, inform the Participant as early as possible in the Restraint process, what is needed for the Restraint to be released.

8. File an incident report any time a Restraint is used as specified in Appendix B.
9. Do not use a Restraint as a punishment, therapeutic technique, or for convenience.

### **2.3 Non-Covered Services**

- A. The Contractor is not responsible for the following:
  1. Non-Capitation Services unless they are Authorized Services.
  2. Services or supplies provided outside the Commonwealth of Pennsylvania, except for Emergency Services that are Covered Services.
  3. Services not prescribed or recommended by a health care provider acting within the scope of his or her practice.
- B. The Contractor may, at its option and sole expense, provide any services or items that are not Capitation Services. Any service or item that the Contractor opts to provide under this Section must be generally available to all Participants and be authorized if medically necessary. Participants may not be held liable for the cost of such services.

### **2.4 Service Authorization**

- A. The Contractor may not require prior authorization for Physician, Chiropractor, CRNP, and Respiratory Care services but may require that these services require a referral from the Participant's PCP. The Contractor shall prior authorize all other Capitation Services, in accordance with the practice guidelines for authorization decisions developed as specified in Section 2.1.Y and the procedures in this Section.
- B. The Contractor must develop written policies and procedures for timely resolution of requests submitted on behalf of a Participant.

to initiate, terminate, reduce, or continue a service, including the role of the PCP and Team, consistent application of the practice guidelines for authorization decisions developed as specified in Section 2.1 Y, and consultation with the requesting Provider when appropriate.

- C. Any decision to deny a request for a service or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has the appropriate clinical expertise in treating the Participant's condition or disease and who was not involved and does not supervise a person involved in the development of the Participant's Initial ISP and FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan.
- D. The Contractor may not structure compensation to individuals who review requests for services in a manner that provides incentives for the individual to deny, limit, or discontinue Medically Necessary services to a Participant.
- E. Each Authorized Service must be the least-restrictive, most-inclusive, and cost-effective feasible option that meets the Participant's needs.
- F. Services may be denied or authorized in an amount, duration, or scope less than requested only on the basis of lack of medical necessity or inconsistency with accepted medical and behavioral health practices and professional standards.
- G. The amount, duration, or scope of a service may not be arbitrarily denied, reduced, or terminated solely because of the diagnosis, illness, or condition of a Participant.
- H. Any request to authorize care in a Nursing Facility, ICF, or Residential Supports setting must be submitted to BAS for review prior to authorization on the form provided by BAS, and include the FBA-Based ISP. The review by BAS will be within the timeframes for authorization specified in this Section.
- I. Within five (5) days of the Team meeting to develop the Initial ISP or the FBA-Based ISP the Supports Coordinator must submit the Initial ISP or the FBA-Based ISP and supporting documentation to the Behavioral Health Practitioner for authorization of the services

specified in the Initial ISP or FBA-Based ISP. If the Team was unable to reach a consensus on which services to include in an ISP or the amount, duration, or scope of a service include in an ISP, the Supports Coordinator must identify the services on which the Team did and did not reach consensus and explain the positions taken by the Team members for the services on which the Team did not reach consensus.

- J. After the Behavioral Health Practitioner receives the Initial ISP or the FBA Based ISP from the Team, he or she must, in consultation with the Medical Director as appropriate, resolve any areas in the ISP on which the Team did not reach consensus and decide whether to authorize services for the Participant. The Behavioral Health Practitioner may:
1. Authorize services as specified on the ISP,
  2. Deny one or more services or authorize a different amount, duration, or scope of one or more services in the ISP, or
  3. Request additional information from the Team to support the services included in the ISP or the amount, duration, or scope of a service included in the ISP.
- K. The decision on the Initial ISP and the FBA-Based ISP must be communicated to the Supports Coordinator and PCP in writing at the same time the Participant or the Participant's representative, as appropriate, is notified of the decision on the ISP. The notice must explain the rationale for the decision and identify any changes between the authorized ISP and the ISP submitted by the Team.
- L. The Contractor must notify the Participant or the Participant's representative as appropriate, in writing using a document approved by the Department, in addition to the notification to the Supports Coordinator and PCP, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must include the decision; the specific reasons for the decision; instructions on how a Participant can file a Grievance if he or she does not agree with the decision and, after exhausting the Grievance process, request a DPW Fair Hearing; information on the Participant's right to request expedited review if the Participant's

treating practitioner believes that the Participant's life, health, or ability to regain maximum function would be seriously jeopardized absent provision of the service in dispute; and the Participant's right to have benefits continue pending resolution of the Grievance or DPW Fair Hearing; and how to request that benefits be continued. The notice must be written in language that is readily understandable by a layperson, at a fourth-grade reading level whenever possible.

M. Time Frames for Service Authorization:

1. Standard Service Authorizations

- a. The Contractor must notify the Participant or the Participant's representative, as appropriate, of the decision to approve or deny a request for services or to authorize a service in an amount, duration, or scope less than requested as expeditiously as the Participant's condition requires, at least orally, no later than five (5) days after receiving the request for service unless additional information is needed. If no additional information is needed, the Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.
- b. If additional information is needed to make a decision, the Contractor must request such information within three (3) days of receiving the request and allow seven (7) days for submission of the additional information. If the Contractor requests additional information, the Contractor must notify the Participant or the Participant's representative, as appropriate, on the date the additional information is requested, using the template found in Appendix F.
  - i. If the requested information is provided within seven (7) days, the Contractor must make the decision to approve or deny the service and notify the Participant or the Participant's

representative, as appropriate, of the decision orally within two (2) business days of receipt of the additional information. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

- ii. If the requested information is not received within seven (7) days, the Contractor must make the decision to approve or deny the service based upon the available information and notify the Participant or the Participant's representative, as appropriate, of the decision orally within two (2) business days after the additional information was to have been received. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

## 2. Expedited Service Authorizations

- a. If a request to authorize the services specified in the Initial ISP or the FBA-Based ISP includes a certification from any member of the Team that the Participant's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular authorization process, the Contractor must notify the Participant or the Participant's representative, as appropriate, of the decision to approve or deny a request for services or to authorize a service in an amount, duration, or scope less than requested as expeditiously as the Participant's condition requires, at least orally, no later than three (3) business days after receiving the request for services unless additional information is needed.

- b. If no additional information is needed, the Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.
- c. If additional information is needed to make a decision, the Contractor must request such information within one (1) business day of receiving the request and allow one (1) business day for submission of the additional information.
  - i. If the requested information is provided within one (1) business day, the Contractor must make the decision to approve or deny the service and notify the Participant or the Participant's representative, as appropriate, of the decision orally within one (1) business days of receipt of the additional information. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.
  - ii. If the requested information is not received within one (1) business day, the Contractor must make the decision to approve or deny the service based upon the available information and notify the Participant or the Participant's representative, as appropriate, of the decision orally within one (1) business days after the additional information was to have been received. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Support Coordinator; and the

prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

3. In all cases, the Contractor must make the decision to approve or deny a request for services so that the Participant or the Participant's representative, as appropriate, receives written notification of the decision no later than twenty-one (21) days from the date the Contractor received the request, or the request is deemed approved. To satisfy the twenty-one (21) day time period, the Contractor must hand deliver the notice by the twenty-first (21<sup>st</sup>) day or mail written notice to the Participant or the Participant's representative, as appropriate, on or before the eighteenth (18<sup>th</sup>) day from the date the request is received. If the notice is not hand delivered by the twenty-first (21<sup>st</sup>) day or mailed by the eighteenth (18<sup>th</sup>) day after the request is received, then the request is deemed approved.
4. If a Participant is currently receiving a requested service and the request to continue the services is denied, or a decision is made to reduce or terminate the service during the authorization period, the written notice of decision must be mailed to the Participant at least ten (10) days prior to the effective date of the decision. If the Contractor has verified probable Participant fraud, notice must be mailed at least five (5) days before the effective date of the decision. Advance notice is not required when the Contractor has factual information of the following:
  - a. Confirmation of the death of the Participant;
  - b. A signed written statement from the Participant requesting service termination or giving information requiring termination or reduction of services (and the Participant understands that this will be a result of supplying that information);
  - c. The Participant's health care practitioner prescribed a change in the level of care;



- d. The Participant has been admitted to an institution where he or she is ineligible to receive services through the Plan;
  - e. The Participant's whereabouts are unknown, and the post office returns Contractor mail directed to the Participant with no forwarding address; or
  - f. Confirmation that the Participant has been accepted for Medicaid services by another State.
- N. If the Participant or the Participant's representative does not agree with the service authorization decision, he or she may file a Grievance and, after exhausting the Grievance process, request a DPW Fair Hearing, as specified in Appendix G.
- O. Within four (4) business days of authorizing services for the Participant, the Contractor must enter into the Department's Home and Community Services Information System (HCSIS) or the Contractor's Total Record database (Total Record), as specified by BAS, the Participant's Initial ISP and FBA-Based ISP, including the Behavioral Support Plan and Crisis Intervention Plan, and a summary of the findings from and the scores on each assessment used to develop the ISP. The Contractor will transfer any information entered into Total Record to HCSIS within twenty (20) business days of receiving notification from BAS that HCSIS is available to receive the information.

## **2.5 Administration**

- A. The Contractor shall establish a Governing Body as the Contractor's policymaking body.
  - 1. The Governing Body is responsible for planning, organizing, administering, overseeing, and evaluating the operations and performance of the Plan.
  - 2. The Governing Body is responsible for the fiduciary obligations of the Contractor and for ensuring that the Contractor satisfies its obligations to the Department and Participants.

3. The Governing Body shall be composed of individuals with knowledge and experience appropriate to the Governing Body's functions.
  4. The Contractor shall provide the Department with the names and positions of the members of the Governing Body within five (5) days of receiving a request from the Department.
- B. The Contractor shall establish a Plan Advisory Committee.
1. The Plan Advisory Committee shall be appointed by the Governing Body.
  2. The Plan Advisory Committee shall include the Medical Director, a Behavioral Health Practitioner, a parent of an adult with ASD, providers representing the scope of services provided under the Plan, and representatives from the religious, law, and ethics communities.
  3. The Plan Advisory Committee will report to and advise the Governing Body and establish Committees in accordance with the terms of this Agreement on matters related to the Complaint and Grievance Processes; Quality Management and Utilization Review Processes; and Ethics.
- C. The Service Area for this Agreement includes the counties of Cumberland, Dauphin, Lancaster and Chester.
- D. Protocol
- The Contractor shall complete the Protocol document provided by the Department (see Appendix H) and submit the completed document no later than fifteen (15) days after signing this Agreement for Department approval. The Department-approved document shall be incorporated into and become part of this Agreement.
- E. Information Systems
1. Within thirty (30) days of signing this Agreement, the Contractor shall obtain and purchase all compatible computer software and required licenses for the Contractor's and the Department's use as may be necessary to allow for

electronic communication and transfer of information between the Contractor and the Department. The software the Contractor purchases must allow the Contractor to collect, analyze, integrate, and report data.

2. The Contractor shall backup all electronically stored information daily. The backup file(s) must be in a separate location apart from the primary storage site.

F. Assignment of Contract

The Contractor may not assign any right or delegate any duty or obligation imposed by this Agreement; however, except as specified in Section 2.1.F, the Contractor may meet its obligations under this Agreement by purchasing services from other qualified providers of such services.

G. Purchase of Service Subcontracts with Providers

1. The Contractor is accountable for the satisfactory performance of its Providers, including compliance with the terms of this Agreement and with governing federal and state statutes and regulations, and no subcontract shall operate to terminate or mitigate the Contractor's obligations under this Agreement.
2. All subcontracts for the purchase of services provided to Participants must be in writing, fulfill the requirements of this Agreement, be appropriate to the subcontracted service or activity, and contain provisions consistent with the terms of this Agreement. Each subcontract must include, at a minimum, the following:
  - a. A provision that identifies the subcontracted activities and reporting responsibilities;
  - b. A provision that specifies the timeframes within which services must be delivered;
  - c. The payment arrangement(s) between the Contractor and the Provider and the procedure for resolving payment disputes;

- d. A provision that prohibits the Provider from seeking payment from the Department for any reason, including nonpayment by the Contractor;
- e. A provision that prohibits the Provider from holding any Participant liable for payment for an Authorized Service for any reason, including nonpayment by the Contractor or the Department;
- f. A provision that requires the Provider to comply with the requirements of Title XIX of the Social Security Act and accompanying regulations and the Department's regulations that govern the Medical Assistance Program;
- g. A provision that requires the Provider to obtain all required licenses, certifications, credentials, and permits from federal, state, and local authorities and comply with all applicable state and federal statutes and regulations that pertain to Participant rights, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; the Health Information Protection and Accountability Act; and regulations promulgated under each statute;
- h. The sanctions, including termination, that can be imposed if the Provider's performance is inadequate;
- i. A provision that requires the Provider to make available to the Contractor, the Department, and other federal and state officials, upon request, all records relating to the delivery of and payment for services delivered under the subcontract.
- j. A provision that requires the Provider to maintain professional malpractice and all other types of insurance in such amounts as required by applicable laws.

3. The Contractor may not enter into capitation arrangements with Providers.
4. Each Provider must be enrolled in the Medical Assistance Program.
5. The Contractor must ensure that each Provider responds, reports, and follows up on critical incidents as specified in Appendix B.
6. The Contractor must ensure that all Provider facilities and offices are accessible to individuals with disabilities.
7. No later than when it enters in a subcontract with a Provider, the Contractor must inform the Provider of the following:
  - a. The right of each Participant, or the Participant's representative acting on behalf of the Participant, which may include the Participant's Provider, with the Participant's written authorization to act on the Participant's behalf, to file a Complaint or Grievance; the requirements and timeframes for filing a Complaint or Grievance as specified in Appendix G; the availability of assistance in the filing process; the toll-free numbers that the Participant can use to file a Complaint or Grievance; and the ability to continue to receive requested services if the Participant files a Grievance within ten (10) days of the notice to terminate or reduce currently Authorized Services.
  - b. The right of each the Participant, or the Participant's representative acting on behalf of the Participant, to quest a DPW Fair Hearing; the methods for obtaining a DPW Fair Hearing; the timeframe for requesting a DPW Fair Hearing after filing a Complaint or Grievance; the rules that govern representation at DPW Fair Hearings; and the ability to continue to receive requested services if the Participant files a request for a DPW Fair Hearing within ten (10) days of the

Grievance decision to terminate or reduce currently Authorized Services.

8. When the Contractor or BAS identifies deficiencies or areas for improvement in a Provider's performance, the Contractor and Provider must take corrective action to ensure that the Provider removes the deficiencies and improves its performance.
9. The Contractor must make a good faith effort to give written notice of the termination of a Provider within seven (7) days after receiving notice of the Provider's intent to terminate or issuing notice to the Provider of the Contractor's intent to terminate the Provider, to each Participant for whom the Provider served as a PCP or who otherwise received services from the Provider on a regular basis. The Contractor must ensure continuity of service when a Provider is terminated.

#### H. Provider Selection

1. The Contractor may not preclude any potential provider who is acting within the scope of his or her license or certification under State law from participating in the Network or refuse to make payments to a Provider, solely on the basis of that license or certification.
2. The Contractor must submit written policies and procedures for the selection and retention of Network Providers within fifteen (15) days after signing this Agreement for approval by the Department. Those policies and procedures must include standards and procedures for credentialing and re-credentialing Network Providers that are consistent with this Section.
3. The Contractor may not discriminate against potential providers who serve high-risk populations or specialize in conditions that require costly treatment.
4. The Contractor may not subcontract with providers that have been excluded from participation in Medicare or any State Medicaid or other health care program.

5. In establishing and maintaining a Network sufficient to provide prompt access to Capitation Services and other Covered Services, the Contractor must consider the following:
  - a. The anticipated number of Participants.
  - b. The expected utilization of services considering the needs of the population being served.
  - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Capitation Services and other Covered Services.
  - d. The geographic location of Network Providers compared to Participants, considering distance, travel time, the means of transportation ordinarily used by Medical Assistance recipients, and whether the location provides physical access for Medical Assistance recipients with disabilities.
6. The Contractor may use different payment amounts for different specialties or for different practitioners in the same specialty.
7. The Contractor shall notify providers in writing when they are denied participation in the Contractor's network. Notification must include the reason for the denial.

I. Personnel Requirements

1. The Contractor shall hire, at a minimum, the following personnel;
  - a. Executive Director  
The Executive Director is responsible for the oversight, administration and day-to-day operations of the Plan and is accountable to the Governing Body. The Executive Director may be changed during the period of this Agreement only after written notice to the Department. The Executive Director shall be authorized to represent the Contractor with respect to

all matters related to implementation of this Agreement.

- b. Medical Director  
The Medical Director must be a physician licensed to practice in the Commonwealth of Pennsylvania. The Medical Director is responsible for the management of the physician and physical health services provided to Participants and for advising the Contractor and Plan Advisory Committee on health-related issues.
  
- c. Two Behavioral Health Practitioners  
The Behavioral Health Practitioner must have at least a Master's Degree in Social Work, Psychology, Education, or a related human services field and five years experience in administering or interpreting functional behavioral assessments applied to persons with severe behavioral problems including persons with ASD. The Behavioral Health Practitioner is responsible for overseeing the work of the Behavioral Health Specialist, authorizing services recommended in the Initial ISP and FBA-Based ISP, and advising the Contractor and Plan Advisory Committee on behavioral-health-related issues.
  
- d. Chief Financial Officer
  
- e. Supports Coordinator  
A Supports Coordinator must have at least a Bachelor's Degree in Education, Psychology, Social Work, or other related human services or social sciences field. The Supports Coordinator provides Support Coordination as defined in Appendix D. Supports Coordinators must be employees of the Contractor, except that during the first six (6) months after the first Participant is enrolled in the Plan, Supports Coordinators may be employed by another agency for one (1) month after they begin working for the Contractor.
  
- f. Habilitation Worker  
A Habilitation worker must be at least eighteen (18) years of age and have a high school diploma or



equivalent. The Habilitation Worker provides Habilitation as defined in Appendix D. Habilitation Workers must be employees of the Contractor, except that during the first six (6) months after the first Participant is enrolled in the Plan, Habilitation Workers may be employed by another agency for one (1) month after they begin working for the Contractor.

2. Prior to altering the levels of effort of the Executive Director, the Medical Director, the Behavioral Health Practitioner, or the Chief Financial Officer among various activities under this Agreement or to diverting those individuals to other projects outside the scope of this Agreement, the Contractor shall notify the Department at least ten (10) days in advance and shall submit justification in sufficient detail to permit evaluation of the impact on the Plan. The Contractor may not alter or divert the level of effort of these personnel from the specified activities without the Department's approval.
3. The Contractor shall supply to the Department, within ten (10) business days of request, the names of the personnel who are required to be employees of the Contractor.
4. The Contractor shall retain the services of Behavioral Health Specialists, who need not be employees of the Contractor. A Behavioral Health Specialist must have at least a Master's Degree in Social Work, Psychology, Education, or a related human services field. A Behavioral Health Specialist is a required member of each Participant's Team, and is responsible for conducting a Functional Behavioral Assessment, developing a Behavioral Support Plan, and delivering Behavioral Support.

J. Third Party Liability (TPL)

The Contractor must comply with the Third-Party Liability (TPL) procedures set forth at Section 1902(a)(25) of the Social Security Act, 42 U.S.C. § 1396(a)(25), and implemented by the Department. Under this Agreement, the Third-Party Liability responsibilities of the Department will be allocated between the Department and the Contractor.

1. Cost Avoidance Activities

- a. The Contractor shall be responsible for cost avoidance through the Coordination of Benefits (COB) for public and private resources, including but not limited to Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, et. seq., plans, and workers' compensation. The Contractor must attempt to avoid initial payment of Claims, whenever possible, where public or private resources are available. All cost-avoided funds must be reported to the Department on a form approved by the Department, showing that TPL has been pursued and the amount which has been cost-avoided. The Contractor shall not be held responsible for any TPL errors in the Department's Eligibility Verification (EVS) or the Department's TPL file.
- b. The Contractor may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The Contractor may neither unreasonably delay payment nor deny payment of claims unless it has established the probable existence of TPL at the time the Claim is adjudicated.

## 2. Post-Payment Recoveries

- a. Post-payment recoveries are categorized by:
  - (i) Health-related insurance resources, and
  - (ii) Other Resources.

Health-related insurance resources are Medicare, ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, private health insurance, workers' compensation, and health insurance contracts.

- b. The Contractor has the sole and exclusive responsibility and right to pursue, collect, and retain all health-related insurance resources for a period of nine (9) months from the date of service or six (6)

months after the date of payment, whichever is later. The Contractor must indicate its intent to recover on health-related insurance by providing to the Department an electronic file of those cases that will be pursued. The cases must be identified and a file provided to the Department by the Contractor within the window of opportunity afforded by the nine (9) months from the date of service or six (6) months after the date of payment unless otherwise granted by the Department. The Department's Division of TPL may pursue, collect, and retain recoveries of all health-related insurance cases which are outstanding, that is, not identified by the Contractor for recovery, after the later of nine (9) months from the date of service or six (6) months after the date of payment. Notification of intent to pursue, collect, and retain health-related insurance is the sole responsibility of the Contractor, and cases not identified for recovery will become the sole and exclusive right of the Department to pursue, collect, and retain. In such cases where the Contractor has identified the cases to be pursued, the Contractor shall retain the exclusive responsibility for the cases for a period not to exceed eighteen (18) months. The calculation of the eighteen (18) month period shall commence with receipt of the file from the Contractor identifying the cases to be pursued. Any case not completed within the eighteen (18) month period will become the sole and exclusive right of the Department to pursue, collect, and retain. The Contractor is responsible to notify the Department through the prescribed electronic file process of all outcomes for those cases identified for pursuit.

- c. As part of its authority under subparagraph 2.a.(i) above, the Contractor is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has improperly denied payment based upon either a lack of Medically Necessary determination or lack of coverage.
- d. Should the Department lose recovery rights to any claim due to late or untimely filing of a claim with the liable third party, and the untimeliness in billing that

specific claim is directly related to untimely submission of records, or inappropriate denial of claims for accidents or emergency care in casualty-related situations, the amount of the unrecoverable claim shall be assessed against the Contractor.

- e. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all Other Resources, which include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance. Any correspondence or Inquiry forwarded to the Contractor (by an attorney, provider of service, insurance carrier, or other entity) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding a Participant and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Contractor may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Department under the scope of these "Other Resources" shall be retained by the Commonwealth.
- f. Should the Department fail to identify and establish a claim prior to settlement due to the Contractor's untimely submission of notice of legal involvement where the Contractor has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Contractor. The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

### 3. Estate Recovery

Section 1412 of the Public Welfare Code, 62 P.S. § 1412, requires the Department to recover Medical Assistance costs paid on behalf of certain deceased individuals. Individuals

age fifty-five (55) and older who were receiving Medical Assistance benefits for any of the following services are affected:

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

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

4. Requests for Additional Information

The Contractor must provide, at the Department's request, such information that may be necessary for the administration of TPL activity. The Contractor must use its best efforts to provide this information within fifteen (15) days of the Department's request. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information must be maintained as required by federal and state statutes and regulations.

K. Physician Incentive Plans

The Contractor shall not enter into physician incentive plans as defined in 42 CFR § 422.208(a).

L. Advance Directives

The Contractor must:

1. Maintain written policies and procedures that meet the requirements for Advance Directives of 42 CFR § 422.128, State law, and applicable Department bulletins. The policies and procedures must be updated to reflect any changes in

state law no later than ninety (90) days after the effective date of the change and must be made available to the Department upon request.

2. Provide written information to all Participants at enrollment concerning the Contractor's policies and procedures on Advance Directives, including a statement of any limitation regarding the implementation of an Advance Directive as a matter of conscience, and inform Participants of the right to request this information annually.

M. Risk Reserve

1. The Contractor shall maintain a risk reserve approved by the Department in the event the Contractor becomes insolvent. The risk reserve accounts must be separate from any operating accounts. The Contractor must demonstrate that it has arrangements in place in the amount of one (1) month's total capitation revenue and one (1) month's average payment to Providers to cover expenses in the event it becomes insolvent.
2. The requirement in this Section may be met by one or more of the following arrangements:
  - a. Insolvency insurance;
  - b. An irrevocable, unconditional and automatically renewable letter of credit for the benefit of the Department, which is in place for the entire term of this Agreement;
  - c. A guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or
  - d. Other arrangements, satisfactory to the Department, that are sufficient to ensure payment to Providers in the event of a default in payment resulting from bankruptcy or insolvency.

N. **Liability for Payment**

The Contractor shall not hold Participants liable for the Contractor's debts in the event of insolvency.

**ARTICLE III: PAYMENT PROVISIONS**

**3.1 Capitation Payment**

- A. The Department will pay a Capitation Payment to the Contractor for each Participant calculated on an actuarially sound basis. The Capitation Payment rates and methodology for calculating the rates are described in Appendix I.
- B. The Department will pay the Contractor a Capitation Payment for each Participant as of the effective date of the Participant's enrollment.
- C. Payment to the Contractor will be automatically generated on a monthly basis via the Provider Reimbursement and Operations Management Information System (PROMISE™). The Contractor will receive payment from the Department at the current Capitation Rate minus any applicable Participant Liability amount. The Contractor is responsible to collect any Participant Liability amount from the Participant.
- D. The Contractor shall accept the Capitation Payment and any applicable Participant Liability as payment for providing or arranging for all Medically Necessary Authorized Services to Participants as described in Article II.
- E. The Contractor shall be liable for payment of all claims for Authorized Services provided to a Participant from the effective date of the Participant's enrollment in the Plan.
- F. Except as specified in Section 3.1.G, the Capitation Payment for a disenrolled individual shall be terminated effective on the date of disenrollment. The effective date of disenrollment is the last day of the month in which the Participant is disenrolling. Should the Contractor receive any Capitation Payment for an individual after the effective date of disenrollment, the overpayment to the

Contractor shall be reconciled as a payment adjustment described in Section 3.2.A.

- G. The Capitation Payment for a Participant who is between 22 and 65 years of age and is admitted to an IMD shall be terminated the day after admission to the IMD. Should the Contractor receive any Capitation Payment for the time after the individual is admitted to an IMD, the overpayment to the Contractor shall be reconciled as a payment adjustment described in Section 3.2.A.

### **3.2 Reconciliation**

#### **A. Payment Adjustment Process**

In the event that the Contractor receives an incorrect payment from the Department, the Contractor will immediately notify the Department. The Department will then initiate the appropriate payment adjustment via PROMISe™.

#### **B. Rate Adjustment Process**

1. The Capitation Rates shall be calculated annually to be effective on the first day of the Department's fiscal year. The Department will make its best effort to determine the rate prior to the start of the fiscal year. If the Department is unable to determine the rate before July 1, payment will continue to be made at the previous year's Capitation Rate until such time as the new rate has been established
2. If payment has been made at the previous year's Capitation Rate during any portion of a new fiscal year, the Department will make a payment adjustment in the amount that results from the difference between the new Capitation Rate and the previous year's Capitation Rate.

### **3.3 Risk**

The Contractor and the Department assume a risk sharing arrangement limited to any excess service costs or savings outside of a fifteen percent (15%) range above and below the service portion of the Capitation Rate. The amount above or below the fifteen percent (15%) range will be shared



on an 80/20 basis between the Department and the Contractor, respectively. The risk-sharing calculation will be performed for the total service cost experience from the beginning of this Agreement through June 2009.

#### **ARTICLE IV: OUTREACH AND ENROLLMENT**

##### **4.1 Outreach and Marketing**

A. The Contractor shall:

1. In conjunction with the Department, promote ACAP to Medical Assistance recipients in the Service Area and, when appropriate, in the regional offices of the Department.
2. Obtain approval from BAS of its plan for outreach, marketing, and enrollment on an annual basis or when changes occur. The plan shall include: how outreach to potential Applicants will be made; how ACAP will be promoted; a schedule for the sequence and timing of promotional and enrollment activities in the Service Area; and development and procurement of resources needed for implementation.
3. Obtain approval from BAS prior to use of all outreach and marketing materials which are produced in any medium by or on behalf of the Contractor and can reasonably be interpreted as intended to influence a person to enroll in Contractor's Plan.
4. Develop and publish outreach and marketing materials that are easy to understand in English and in the prevalent non-English languages spoken in the Service Area. "Prevalent" means a non-English language spoken by five percent (5%) or more of the individuals living in the Service Area who may be eligible to enroll in ACAP.
5. Notify potential Applicants that outreach and marketing materials are available in prevalent non-English languages and explain how to access those materials and notify potential Applicant's that oral interpretation services are available for all outreach and marketing materials in all

languages free of charge and explain how to access the services.

6. Develop and publish outreach and marketing materials in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency, and inform potential Applicants that alternative formats are available and how to access them.
7. Inform potential Applicants of the basic features of the Plan, which populations are eligible and ineligible for ACAP, and the Plan's responsibilities for coordinating care.
8. Provide a summary, and make available more detailed information upon request, of the services provided; the Service Area; the names, locations, telephone numbers of, and non-English language(s) spoken by Network Providers, and the Network Providers that are not accepting new patients; benefits that are available under the Medical Assistance Program, but are not Covered Services, including how and where the Participant may obtain those benefits; any cost sharing; and how transportation is provided.
9. Inform potential Applicants of their ability to terminate enrollment voluntarily at any time.
10. Ensure that all staff and Providers who have contact with potential Applicants are fully informed of and understand the Contractor's policies for outreach, enrollment, and disenrollment.
11. Distribute its outreach and marketing materials in the entire Service Area.

B. The Contractor shall not:

1. Seek to influence enrollment in conjunction with the sale or offering of any private insurance.
2. Seek to influence an Applicant's decision to enroll by stating or implying, either orally or in writing that the Applicant

must enroll in the Plan in order to obtain benefits or in order not to lose benefits.

3. Directly or indirectly engage in door-to-door, telephone, or other unsolicited personal contact with a potential Applicant for the purpose of marketing including any communication to a Medical Assistance recipient who is not enrolled in ACAP, that can reasonably be interpreted as intended to influence the potential Applicant to enroll in ACAP, or either to not enroll in or to disenroll from another Medical Assistance Program.
4. Seek to influence a potential Participant's decision to enroll by stating or implying, either orally or in writing, that the Contractor is endorsed by CMS, the Federal government, the Department, or a similar entity.
5. Use any marketing incentive to influence a potential Participant.

#### **4.2 Participant Handbook and Enrollment Agreement**

- A. The Contractor shall use the Participant Handbook specified by the Department and Enrollment Agreement template specified by the Department.
- B. The Participant Handbook must include the following:
  1. A description of all Capitated Services provided through the Plan, in sufficient detail to enable the Participant or the Participant's representative, if appropriate, to understand the benefits available under the Plan.
  2. An explanation of the circumstances under which the Contractor is responsible for Post-Stabilization Care Services.
  3. An explanation of the procedure for obtaining Capitated Services, including authorization requirements.
  4. Information on the Participant's right to choose his or her PCP and other Providers to the extent possible and

appropriate, including information on any restrictions on the Participant's freedom of choice among Network Providers.

5. Locations, telephone numbers, and procedures for obtaining health services in the event of a crisis.
6. The names, locations, telephone numbers, service(s) provided, and identification of non-English languages spoken by Network Providers in the Service Area.
7. Participant rights and responsibilities, as defined in this Section.
8. The disenrollment procedures, as described in Section 4.4 of this Agreement.
9. Information concerning transportation arrangements offered by the Contractor.
10. The extent to which and how Participants may obtain benefits from Non-Network Providers.
11. An explanation of how and where to access any benefits, including family planning services, that are available under the Medical Assistance Program but are not covered under this Agreement, including any cost sharing.
12. The extent to which, and how, after-hours and emergency coverage are provided.

C. The Contractor must inform each Participant verbally and in the Participant Handbook of the following rights and responsibilities:

1. The Contractor's responsibility to respond to any questions or concerns the Participant has about the care rendered and to routinely check with the Participant about his or her satisfaction with the services being rendered.
2. The Contractor's responsibility to render services according to acceptable standards of care.
3. The Contractor's responsibility to provide care according to the Initial ISP and the FBA-Based ISP.

4. The Contractor's responsibility to notify the Participant in writing of any action taken which affects the status of the Participant's services.
5. The Contractor's responsibility to provide information on request regarding the structure and operation of the Plan.
6. The Participant's responsibility to treat employees of the Contractor and Providers with respect and to communicate problems immediately to the appropriate Contractor staff.
7. The Participant's responsibility to notify the appropriate Contractor's staff and Providers whenever Participant is unable to keep an appointment.
8. The Participant's responsibility for Participant Liability, if such liability exists.
9. The Participant's responsibility to obtain a referral for services when required.
10. The Participant's right to be treated with respect and with due consideration for his or her dignity and privacy.
11. The Participant's right to receive all materials in a language, manner, and format that is easily understood.
12. The Participant's right to written information in the prevalent non-English languages of the Service Area and in an appropriate alternative format or manner that takes into consideration the special needs of Participants who, for example, are visually limited or have limited reading proficiency.
13. The Participant's right to free oral interpretation services in any language.
14. The Participant's right to file a Complaint or Grievance, the requirements and timeframes for filing a Complaint or Grievance as specified in Appendix G, the availability of assistance in the filing process, the toll-free numbers that the Participant can use to file a Complaint or Grievance, and

the ability to continue to receive requested services if the Participant files a Grievance within ten days of the notice to terminate or reduce currently Authorized Services.

15. The Participant's right to request a DPW Fair Hearing, the methods for obtaining a DPW Fair Hearing, the timeframe for requesting a DPW Fair Hearing after filing a Complaint or Grievance, the rules that govern representation at DPW Fair Hearings, and the ability to continue to receive requested services if the Participant files a request for a DPW Fair Hearing within ten (10) days of the Grievance decision to terminate or reduce currently Authorized Services.
16. The Participant's right to receive information on available treatment options and alternatives presented in a manner appropriate to the Participant's condition and ability to understand.
17. The Participant's right to participate in decisions regarding his or her health care, including the right to refuse treatment.
18. The Participant's right to be free from any form of Restraint used as a means of coercion, discipline, convenience or retaliation.
19. The Participant's right to be free from seclusion at any time.
20. The Participant's right to request and receive copies of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

D. Prior to enrollment, the Contractor shall:

1. Review the Participant Handbook and the Enrollment Agreement with each Participant or the Participant's representative, as appropriate;
2. Provide each Participant or the Participant's representative, as appropriate, with a copy of the Participant Handbook and the Enrollment Agreement;

3. Obtain the signature of the Participant or the Participant's representative, as appropriate, on the Enrollment Agreement and on a written statement verifying review and receipt of the Participant Handbook and give the Participant or the Participant's representative, as appropriate, a copy of the Enrollment Agreement and of the signed statement verifying review and receipt of the Participant Handbook.
- E. The Contractor must provide written notice to Participants of any change in the Handbook or Enrollment Agreement and any other significant change, as determined by the Department, to the delivery of Covered Services provided under the Plan, at least thirty (30) days before the intended effective date of change. The change must be approved by the Department prior to providing notification to the Participants.
  - F. The Contractor must inform Participants annually that they may obtain the information contained in the Participant Handbook upon request.

### **4.3 Enrollment**

- A. Number of Participants
  1. Maximum monthly enrollment is limited to two-hundred (200) Participants. The Department may restrict enrollment to fewer than two-hundred (200) Participants. The Department will notify the Contractor each month the maximum number of Applicants that can be enrolled for that month. Enrollment may proceed to the Contractor's maximum number unless restricted by the Department. Restrictions on the number of Participants will be defined in writing and the Contractor notified by the Department at least ten (10) days prior to the start of the period of restriction. Release of restriction will be in writing and transmitted to the Contractor at least ten (10) days prior to the date of the release. Monthly enrollment restrictions do not apply to enrollments to replace loss of Participants due to disenrollment or death.
  2. If the Contractor enrolls Medical Assistance Participants over the number specified by the Department, the Contractor

must provide or arrange for the provision of services and pay for services to those Participants, but the Department will not remit Capitation Payments for those Participants and the Contractor may not require those Participants to pay for the Authorized Services that are provided to them.

3. The Department may increase the maximum enrollment. The Department will notify the Contractor in writing of its intent to increase the maximum enrollment. The Contractor must notify the Department within five (5) days of receiving the Department's notification if the Contractor lacks capacity to serve the increased enrollment.

B. Eligibility

1. To participate in ACAP an individual must meet the following criteria:
  - a. Be twenty-one (21) years of age or older;
  - b. Be eligible for Medical Assistance.
  - c. Have a diagnosis of Autism Spectrum Disorder (ASD);
  - d. Be certified as meeting Medical Assistance Program clinical eligibility for ICF services in the Commonwealth of Pennsylvania;
  - e. Not be enrolled in a Medical Assistance home and community based waiver program at the time of enrollment;
  - f. At the time of enrollment be able to live in a community setting without sixteen (16) or more awake paid and unpaid staff and supervision hours per day without presenting a danger to self or others or a threat to property;
  - g. Does not exhibit levels of extremely problematic behaviors that would present a danger to self or others (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats) or threat to property;



- h. Reside in the Service Area; and
  - i. Not be enrolled in a Medical Assistance Managed Care Organization (MCO) at the time of enrollment in the Plan.
2. The Contractor shall enroll Applicants up to the number of slots specified by the Department in the order in which they apply, without regard to sex, religion, creed, color, handicap, national origin, ancestry, health status or need for health care services.

C. Enrollment Procedures

- 1. The Contractor must refer all inquiries for enrollment to BAS.
- 2. a. BAS will determine whether the Applicant:
  - i. Is 21 years of age or older;
  - ii. Has a diagnosis of ASD;
  - iii. Meets the Medical Assistance Program clinical eligibility for ICF services in the Commonwealth of Pennsylvania;
  - iv. Is not enrolled in a Medical Assistance home and community based waiver program at the time of enrollment;
  - v. Is able to live in a community setting without sixteen (16) or more awake paid and unpaid staff and supervision hours per day without presenting a danger to self or others or a threat to property;
  - vi. Does not exhibit levels of extremely problematic behaviors that would present a danger to self or others (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats) or threat to property;

- vii. Resides in the Service Area; and
  - viii. Is willing to disenroll from a Medical Assistance MCO, if enrolled.
- b. BAS will use the following, as needed, to determine if the Applicant meets the above eligibility requirements:
    - i. Applicant's responses to questions asked during phone intake;
    - ii. Applicant's application for ACAP;
    - iii. Medical Evaluation (MA-51); and
    - iv. Information obtained during BAS's in-home visit with the Applicant, the Applicant's representative, as appropriate, and any family members or others the Applicant may request.
- 3.
    - a. The CAO will determine whether the Applicant is eligible for Medical Assistance.
    - b. If the CAO determines that the Applicant is not eligible for Medical Assistance, the CAO will provide written notice to the Applicant that the Applicant is not eligible for Medical Assistance.
- 4. If BAS determines that the Applicant appears to be eligible for ACAP and the CAO determines that the Applicant is eligible for Medical Assistance, BAS will refer the information it has on the Applicant to the Contractor and notify the Contractor that it wants to participate in the comprehensive in-home assessment.
- 5.
    - a. Upon receipt of the Applicant's referral from BAS, the Contractor must contact the Applicant by the next business day to schedule an appointment with the Applicant and the Applicant's representative, as appropriate, and any family member or others as the Applicant may request, and BAS, if BAS has notified the Contractor that it will be participating, to conduct

a comprehensive in-home assessment, meet and observe the Applicant and his or her family in the home environment, and complete the Scales of Independent Behavior-Revised (SIB-R) and the Quality of Life Questionnaire.

- b. After completing the comprehensive in-home assessment the Contractor must determine if the Applicant:
  - i. Is able to live in a community setting without sixteen (16) or more awake paid and unpaid staff and supervision hours per day without presenting a danger to self or others or a threat to property;
  - ii. Does not exhibit levels of extremely problematic behaviors that would present a danger to self or others (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats) or threat to property;
  - iii. Resides in the Service Area;
  - iv. Is willing to disenroll from a Medical Assistance MCO, if enrolled;
  - v. Is willing to enroll in the Contractor's Plan; and
  - vi. Has a diagnosis of ASD.
- c. The Contractor must notify BAS of its recommendation to approve or deny enrollment as soon as the eligibility determination is made but no later than fifteen (15) days after the comprehensive in-home assessment. This time requirement may be extended for circumstances beyond the Contractor's control with prior approval from BAS. The Contractor must submit a written report describing the basis for the recommendation; the information, documentation, screenings and evaluations or assessments used to make the decision; and names and disciplines of those

involved in the decision to BAS at the time it recommends enrollment or within seven (7) days of making the recommendation to deny enrollment. The Contractor must maintain all supporting documentation related to the denial according to Article VII.

6. If the Contractor recommends enrollment, BAS will notify the Contractor of its decision to approve or disapprove the recommendation within three (3) business days of receipt of the recommendation.
7. If the Contractor recommends that enrollment be denied, BAS will notify the Contractor of its decision to approve or disapprove the recommendation within seven (7) days of receipt of the Contractor's written report.
8. The Contractor must notify the Applicant if the Applicant is eligible to enroll in ACAP.
9. If BAS determines that the Applicant is ineligible for ACAP, BAS will provide written notice to the Applicant that enrollment is denied.
10. If BAS determines that the Applicant is eligible for ACAP, the Contractor will schedule a Team meeting to develop the Initial ISP as specified in 2.1.L. 2. The Contractor shall inform the Applicant that he or she must decide whether to enroll in the Plan within seven (7) days of receiving the authorized Initial ISP. The Contractor shall also inform the Applicant that if the Applicant disagrees with the authorized Initial ISP, the Applicant may choose not to enroll in the Plan or may enroll in the Plan and file a grievance to dispute the services that were authorized.
11. The Contractor must complete all necessary enrollment forms, as specified by BAS, for each Applicant BAS has approved for enrollment and forward all completed enrollment forms to BAS no later than seven (7) days after receiving the forms.
12. If the Applicant chooses to enroll in the Plan, he or she will sign the Enrollment Agreement. The effective date of

enrollment, as specified on the Enrollment Agreement, must be the first day of the month that follows the date the Contractor receives confirmation from BAS that the Applicant's enrollment has been approved as described in Section 4.3.C.6.

13. If the Applicant or the Applicant's representative, as appropriate, informs the Contractor that the Applicant no longer wants to enroll in the Plan, the Contractor must notify BAS within three (3) business days of being so informed by the Applicant.
14. In order to expedite the enrollment process, to ensure timelier enrollment in the Plan, or for any reason the Department deems necessary, the Department may modify the enrollment process. The Department will confirm any such changes to the enrollment process in writing and send notice in accordance with Section 12.7.

D. Annual Recertification

1. Thirty (30) days prior to the annual anniversary of the Participant's enrollment date, the Contractor shall
  - a. Send the necessary completed forms and other information to BAS to redetermine the Participant's clinical eligibility for ICF.
  - b. Be available to assist the Participant in completing the forms and delivering the forms to the appropriate CAO.
2. BAS will notify the Participant of his or her continued eligibility or ineligibility for ACAP based on the annual redetermination of clinical eligibility for ICF.
3. The CAO will notify the Participant of his or her eligibility or ineligibility for Medical Assistance.
4. BAS will notify the Contractor prior to the annual anniversary of the Participant's enrollment of the Participant's continued eligibility or ineligibility for ACAP based on the re-determination of the Participant's eligibility for Medical Assistance and clinical eligibility for ICF.

E. Identification Card Sleeve/Sticker

The Contractor must provide each Participant with a Department-approved identification card sleeve/sticker for the Medical Assistance Card to identify the Participant as a Participant in the Plan. The sleeve/sticker must identify the Participant's name, the Contractor's phone number and the name or title of the contact person for the Contractor, and also specify that emergency services may be rendered to the Participant by Non-Network Providers without prior authorization.

**4.4. Disenrollment**

- A. The Contractor must use the Disenrollment letters in Appendix J.
- B. The Contractor shall assist individuals who disenroll by making appropriate referrals for continuity of care and providing medical records to new providers.
- C. The Contractor shall notify all Providers that were delivering services to an individual who disenrolls that the Provider will not be paid for services rendered after the effective date of disenrollment or, for Participants between 22 and 65 years of age who are admitted to an IMD, that the Provider will not be paid for services rendered after the date of admission to the IMD.
- D. The Contractor shall not terminate enrollment for any reason except as provided in this Section.
- E. Voluntary Disenrollment
  - 1. A Participant may disenroll voluntarily from ACAP at any time without cause. To disenroll, the Participant or, if appropriate, the Participant's representative must notify a member of the Contractor's staff. The Contractor must use the Voluntary Disenrollment Letter in Appendix J to notify the Participant and, if appropriate, the Participant's representative of the last day the Participant can receive Authorized Services.

2. The Contractor shall submit a copy of the Voluntary Disenrollment Letter to BAS within three (3) business days of sending the letter.
3. The Contractor shall inform Participants annually of their right to terminate their enrollment voluntarily at any time.

F. Involuntary Disenrollment

1. The Contractor shall involuntarily disenroll a Participant if the Participant:
  - a. Moves out of the Contractor's Service Area;
  - b. Fails to pay or make satisfactory arrangements to pay the Contractor an amount owed after a thirty (30) day grace period from the due date;
  - c. Falsified or omitted information at application that was used to determine eligibility for enrollment;
  - d. Becomes ineligible for Medical Assistance, except as specified in Section 4.4.F.1.i.;
  - e. Is out of the Contractor's Service Area for more than 30 consecutive days (unless special arrangements are made with the Team);
  - f. Enrolls in a home and community-based waiver or Medical Assistance MCO;
  - g. Engages in uncooperative or disruptive behavior that seriously impairs the Contractor's ability to furnish services to either that Participant or other Participants;
  - h. Misuses (or attempts to misuse) his or her Medical Assistance identification card by attempting to obtain the services provided under this Agreement for any other person, or engages in fraudulent activity involving Medical Assistance benefits; or.

- i. Is between 22 and 65 years of age and is admitted to and remains in an IMD for more than ten (10) days or such longer period of time as BAS specifies.
2. The Contractor shall not involuntarily disenroll any Participant solely because of:
  - a. A change in health or living situation that affects the Participant's ability to remain in the community;
  - b. The Participant's request for a service a Provider does not cover because of moral or religious objections;
  - c. An adverse change in the Participant's health status;
  - d. The Participant's utilization of medical services;
  - e. The Participant's diminished mental capacity; or
  - f. Uncooperative or disruptive behavior resulting from a Participant's special needs (except when his or her continued enrollment would seriously impair the Contractor's ability to furnish services to either that Participant or other Participants).
3. The Contractor must notify BAS within one (1) day of awareness of a situation that may lead to a Participant's involuntary disenrollment.
4. Involuntary Disenrollment Procedures
  - a. The Contractor must submit documentation to BAS supporting the involuntary disenrollment, report that the situation has been resolved or request an extension within ten (10) days of notifying BAS of a situation that may lead to an involuntary disenrollment.
  - b. BAS will notify the Contractor in writing whether it approves or disapproves the involuntary disenrollment within fourteen (14) days of receipt of the Contractor's documentation. If BAS requests additional information, the timeframe for approval or disapproval



begins upon receipt of the additional information. If BAS determines the Contractor has not adequately documented acceptable grounds for disenrollment, the Contractor shall not disenroll the Participant.

- c. The Contractor must use the Involuntary Disenrollment Form in Appendix J to notify the Participant and, if appropriate, the Participant's representative of the decision to involuntarily disenroll the Participant. The Contractor must give the Participant or, if appropriate, the Participant's representative at least thirty (30) days notice of the disenrollment. The notice must include an explanation of the reason for disenrollment, the effective date of the disenrollment, that the Participant will continue to receive services through ACAP until the effective date of the disenrollment, information about how to access services outside of ACAP, the right of the Participant to file a Complaint and request a DPW Fair Hearing after exhausting the Complaint process, and the right of the Participant to continue enrollment after the proposed effective date if the Participant files a Complaint within ten (10) days of receipt of the notice and requests a Fair Hearing within ten (10) days of receiving the notice of the Complaint determination.
- d. The Contractor must provide a copy of the Involuntary Disenrollment Form to BAS and the Participant's CAO.

G. In order to expedite the disenrollment process, to ensure more timely disenrollment from ACAP, or for any reason the Department deems necessary, the Department may modify the disenrollment process. The Department will confirm any such changes to the disenrollment process in writing, and send notice to the Contractor in accordance with Section 12.7.

H. Effective Date of Disenrollment

- 1. The effective date for disenrollment must be on the last day of a month.

2. The effective date of the disenrollment is suspended if the Participant files a Complaint within ten (10) days of receiving notification of disenrollment and requests a DPW Fair Hearing within ten (10) days of receiving the notice of the Complaint determination.

I. Disenrollment Documentation

A discharge summary must be completed for each individual who voluntarily or involuntarily disenrolls from the Plan and be forwarded to the Quality Management Committee for review within ten (10) days of the discharge. The summary must include detailed reasons for the disenrollment, and activities or incidents that led to the disenrollment.

**ARTICLE V: COMPLAINTS, GRIEVANCES, AND DPW FAIR HEARINGS**

**5.1 Complaint, Grievance, DPW Fair Hearing Components**

- A. The Contractor's Plan Advisory Committee shall establish, maintain, and provide support to a Complaint and Grievance Committee that is accountable to the Governing Body on issues addressed by the Committee. Committee membership must include Participants, caregivers, and others to be identified by BAS. This Committee will review the Contractor's performance in carrying out the Complaint and Grievance procedures and make recommendations for improvements to the procedures.
- B. The Contractor shall develop Complaint, Grievance and DPW Fair Hearing procedures that comply with Appendix G. The Contractor's procedures must be approved by BAS before implementation.

**ARTICLE VI: QUALITY MANAGEMENT AND UTILIZATION REVIEW**

**6.1. Quality Management**

- A. Administrative

The Contractor shall:

1. Perform quarterly audits of medical and service records to ensure record entries are appropriate, complete, and legible, and contain all required information such as assessments, progress notes, responsible Provider signatures and recording of services delivered.
2. Establish ongoing mechanisms to monitor Provider compliance with the Department's standard for timely access to care and services as specified in this Agreement and take corrective action if there is a failure to comply.
3. Monitor the performance of its Providers on an ongoing basis, conducting formal review of each Provider at least annually and, if any deficiencies or areas of improvement are identified, take corrective action or require the Provider to take corrective action.
4. Establish and provide support, including staff and alternative forms of communication, to a committee composed primarily of Participants that will report directly to the Plan Advisory Committee on, at a minimum, issues of Participant satisfaction, quality of care, and service delivery.
5. Develop and, after Department approval, implement a plan of Quality Assurance and Improvement that includes the reports specified in Appendix K, which shall be designed to objectively and systematically monitor and evaluate quality and appropriateness of Participant care and identify and resolve problems relating to Participant care. The plan of Quality Assurance and Improvement must include a mechanism to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care furnished to all Participants including those with special health care needs. It must also include a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and service delivery. The plan of Quality Assurance and Improvement shall provide for the periodic submission of reports and records to the Contractor's Governing Body and Plan Advisory Committee.
6. Meet with the Department on a semi-annual basis (or as the Department otherwise requests) to review the Contractor's

performance of all obligations under this Agreement, the development of specific quality goals, the establishment of performance measurement criteria, and other areas the Department deems necessary. The Contractor must submit the reports required by Appendix K to the Department two (2) weeks before it meets with the Department.

B. Quality Management Committee

1. The Plan Advisory Committee shall establish, maintain, and provide support to a Quality Management and Utilization Review Committee, and be accountable to the Governing Body on issues addressed by the Committee.
2. The Quality Management and Utilization Review Committee shall provide guidance and assistance to support the Contractor in carrying out the following Quality Management responsibilities:
  - a. Developing mechanisms for collecting and evaluating information, identifying problems, formulating recommendations, disseminating information, implementing corrective actions, and evaluating the effectiveness of action taken;
  - b. Reviewing annually and making recommendations concerning the formulation, revision or implementation of the policies governing the scope of services offered, practice guidelines, medical supervision, ISPs, crisis intervention care, clinical records, personnel qualifications and program evaluation;
  - c. Providing technical advice regarding professional questions and individual service problems;
  - d. Participating in program evaluation including annual evaluation of the Contractor's performance;
  - e. Assisting in maintaining liaison with professional groups and health providers in the community;

- f. Participating in the development and ongoing review of written policies, procedures, and standards of patient care and quality management;
- g. Reviewing the adequacy and effectiveness of quality management and utilization activities on a quarterly basis; and
- h. Developing mechanisms for evaluating responsiveness of the Complaint and Grievance processes and for collecting and analyzing information about voluntary disenrollments.

C. Ethics Committee

- 1. The Contractor's Plan Advisory Committee shall establish, maintain, and provide support to an Ethics Committee and be accountable to the Governing Body on issues addressed by the Committee. The Committee shall be composed of administration and program staff and the community at large in the fields of primary health care, behavioral health, religion, law, and ethics to represent diversity of Participants.
- 2. Responsibilities of the Ethics Committee shall include the following:
  - a. Reviewing the ethical dimensions of medical, behavioral health, and non-clinical decisions on behalf of Participants and making non-binding recommendations;
  - b. Providing guidance to the Contractor's Governing Body and Plan Advisory Committee on recurring behavioral health and medical-ethical issues;
  - c. Assisting in the development of procedures in documenting Advance Directives, living wills, and general Participant health wishes as required by state and federal law; and
  - d. Providing needed staff training around ethical issues and concerns.

## **6.2 Quality Management Report**

The Contractor shall submit a written report of Quality Management activities including standard measures required by the Department to the Governing Body, Plan Advisory Committee and the Department on an annual basis, which describes topics reviewed, method of review, recommendations for improvement, and evaluation of corrective actions implemented.

## **6.3 Departmental Monitoring**

- A. The Contractor shall cooperate with the Department and the Department's authorized representatives in the Department's monitoring of the Contractor's and Provider's compliance with the requirements specified in this Agreement and the Contractor's and Provider's performance as it relates to Participant outcomes and consistency of quality indicators (See Appendix K). Such monitoring may include routine on-site compliance and quality of care reviews; participation in the Contractor's assessments of Participants and in ISP Team meetings as determined necessary by BAS; review of at least ten percent (10%) of ISPs on an ongoing basis; and on-site visits of Participants' environments. BAS will perform the on-site complaint and quality of care reviews at least annually either unannounced or schedule at a time mutually agreed upon.
- B. The Contractor shall provide BAS access to Total Records within two (2) business days of BAS's request to view the information entered into Total Records.
- C. The Department will report any problems identified during the monitoring reviews to the Contractor for corrective action. The Contractor shall submit a written corrective action plan, which must include the schedule for implementation, to the Department within thirty (30) days of receipt of the Department's report for review and written Department approval, unless the corrective action plan is the result of problems identified during the Department's monitoring of ISPs. If the corrective action plan is required because of problems identified during the Department's monitoring of ISPs, the Contractor shall submit it to the

Department within seven (7) business days of receipt of the Department's report for review and written Department approval. The Contractor shall implement the Department-approved corrective action plan and the Department will monitor implementation.

- D. The Contractor shall comply with requests from the Department for submission of data required to complete an annual external independent review of the quality outcomes and timeliness of, and access to, Authorized Services.

## **ARTICLE VII: RECORD RETENTION, AUDIT, AND INSPECTION**

### **7.1 Records**

The Contractor and Providers shall maintain records, books and data as required by the Department and other regulatory agencies or authorized representatives of the Commonwealth of Pennsylvania and the United States for the purposes of medical and financial audits, inspections, and examinations pertaining to the Contractor's and Provider's performance under this Agreement to the extent and in such detail as shall properly substantiate claims for payment under this Agreement.

### **7.2 Record and On-Site Access**

- A. The Contractor shall preserve and make available to the entities identified in Section 7.1 upon request, books, records, and data that the Contractor is required to maintain under this Agreement for a period of seven (7) years from the termination date of this Agreement. The Contractor shall afford access to these items at its offices and the offices of its Providers at all reasonable times. The Contractor shall retain all documents relating to litigation, adjudicatory proceedings, claims negotiations, audits, or other actions, including appeals, commenced during the term of this Agreement and during the seven-year (7) post-Agreement period, until such proceedings have reached final disposition.
- B. The Contractor shall allow and require its Providers to allow the entities identified in Section 7.1 to have on-site access to the sites where services are provided.

### **7.3 Recovery of Funds**

During the term of this Agreement and after this Agreement is terminated, the Department retains the right to disallow or recover an appropriate amount of funds after fully considering the findings resulting from any audit covering the term of this Agreement. Such audits may be conducted after the termination date.

### **7.4 False Claims**

The Contractor understands that any false claims, statements, or documents may be prosecuted under applicable laws.

### **7.5 Audits**

The Contractor shall cooperate with and require its Providers to cooperate with state and federal agencies or their authorized representatives performing financial and performance audits, as deemed necessary by the Commonwealth of Pennsylvania or Federal agencies. If it is decided that an audit will be performed, the Contractor will be given advance notice, unless the Commonwealth of Pennsylvania or a federal agency determines that an unannounced audit is warranted. The Contractor shall maintain records, which document actual costs, and at the direction of the Department, all books, records and documents related to this Agreement shall be made available for inspection at a site designated by the Department.

## **ARTICLE VIII: CONFIDENTIALITY**

### **8.1 Holder of Data**

- A. The Contractor shall protect all information, records, and data collected in connection with this Agreement from unauthorized disclosure as provided in 42 CFR Chapter 431 Subpart F and 45 CFR Chapters 160 and 164, subparts A and E, and applicable state statutes and regulations. Except as otherwise required by law or as authorized by the Participant, access to such information shall be limited to the Participant, the Contractor, Providers, and the Department or the Department's designee in performance of



duties related to this Agreement. The Contractor shall comply with all applicable statutory and regulatory provisions governing such data and the requirements in the Commonwealth of Pennsylvania, Department of Public Welfare Health Insurance Portability and Accountability Act (HIPPA) Business Associate Agreement and Data Certification (Attachment I).

- B. The Contractor shall inform each of its employees and Providers having any access to personal health information or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to confidentiality.
- C. The Contractor shall return to the Department any and all personal and confidential data furnished pursuant to this Agreement promptly at the request of the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Agreement, the Contractor shall not use any such data or any material derived from the data for any purpose and, where so instructed by the Department, shall destroy such data or material.

## **8.2 Data Security**

The Contractor shall take reasonable steps to ensure the physical security of such data under its control, including but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Participant or Applicant names.

## **ARTICLE IX: TERMS AND CONDITIONS**

### **9.1 Laws and Regulations**

The Contractor shall obtain and require its Providers to obtain all required licenses, certifications, credentials, and permits from federal, state and local authorities needed to implement activities under this Agreement and to comply with all federal, state, and municipal laws, ordinances, and regulations relating to activities under this Agreement, including any applicable Federal and State laws that pertain to Participant rights, including but not limited to Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; the Health Insurance Portability and Accountability Act; and regulations promulgated under each statute.

## **9.2 Representation and Warranties of the Contractor**

- A. The Contractor represents and warrants to the Department that, to the best of its knowledge, it and its Providers have complied with and are complying with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to their property and the conduct of their operations, and no violations of any statute, order, rule, or regulation are existing or threatened.
- B. If, at any time during the term of this Agreement, the Contractor, or any of its Providers, incurs loss of clinical licensure(s), accreditation(s), or state approval(s), the Contractor shall report such loss to the Department no later than the next business day following the discovery of such loss. Such loss may be grounds for termination of this Agreement under the provisions of Section 11.2.

## **9.3 Independent Contractors**

The Contractor, its employees, Providers, or any other of its agents are independent contractors and not officers, employees, or agents of BAS, the Department, or the Commonwealth of Pennsylvania.

## **9.4 Other Contracts**

- A. Nothing in this Agreement shall be construed to prevent the Contractor from operating other comprehensive health care plans

or providing health care services to persons other than those covered under this Agreement. If the Contractor does so, the Contractor shall submit to the Department a complete list of such plans and services, including rates, upon request.

- B. Nothing in this Agreement shall be construed to prevent the Department from contracting with other health care plans in the same Service Area.

### **9.5 Entire Agreement**

This Agreement, including all Attachments and Appendices, constitutes the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with terms and conditions of any written or verbal communication subsequently occurring, except as provided in Section 12.4.

### **9.6 Section Heads**

The headings of the sections of this Agreement are for convenience only and will not affect the construction this Agreement.

### **9.7 Administrative Procedures Not Covered**

Administrative procedures not provided for in this Agreement will be set forth when necessary, in separate memoranda in accordance with Section 12.4.

### **9.8 Effect of Invalidity of Clauses**

If any clause or provision of this Agreement is in conflict with any state or federal statute or regulation, that clause or provision shall be null and void, and any such invalidity shall not affect the validity of the remainder of this Agreement.

### **9.9 Fraud and Abuse**

- A. The Contractor shall develop a written compliance plan that contains the following elements described in CMS publication “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” found at [www.cms.hhs.gov/states/fraud](http://www.cms.hhs.gov/states/fraud):
1. Written policies, procedures, and standards of conduct that articulate the Contractor’s commitment to comply with all Federal and State standards related to Medicaid MCOs.
  2. The designation of a compliance officer and a compliance committee that are accountable to Contractor senior management.
  3. Effective training and education for the compliance officer and MCO employees.
  4. Effective lines of communication between the compliance officer and MCO employees.
  5. Enforcement of standards through well publicized disciplinary guidelines.
  6. Provisions for internal monitoring and auditing.
  7. Provisions for prompt response to detected offenses and the development of corrective action initiatives.
- B. The Contractor shall establish a Fraud and Abuse unit within the organization comprised of experienced Fraud and Abuse reviewers. This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud and Abuse that may be committed by Network Providers, Members, employees, or other third parties with whom the Contractor contracts.
- C. The Contractor shall create and maintain, and submit for Department approval, and comply with written policies and procedures for the prevention, detection, investigation and reporting of suspected Fraud and Abuse, including written policies required under the Deficit Reduction Act, 42 U.S.C. § 1396a(a)(68). The Contractor’s submission of new or revised policies and procedures for review and approval by the Department shall not

act to void or supersede any existing policies and procedures which were previously approved by the Department. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised policies and procedures.

1. The policies and procedures must provide and certify that the Contractor's Fraud and Abuse unit has access to records of Network Providers.
2. The policies and procedures must also contain the following:
  - i. A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, and to recover overpayments or otherwise sanction Providers.
  - ii. A description of specific controls in place for Fraud and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, Claims edits, post processing review of Claims, and record reviews.
  - iii. The Contractor must develop a certification process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management.
- D. The Contractor shall establish a policy on referral of suspected Fraud and Abuse to the Department.
- E. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, Providers, subcontractors and subcontractors' employees about Medical Assistance laws, the Contractor's policies and procedures for preventing and detecting Fraud and Abuse, and the rights of employees to act as whistleblowers.
- F. The Contractor and its employees shall cooperate fully with centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities. Such agencies include, but

are not limited to, the Department's Bureau of Program Integrity, Governor's Office of the Budget, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the CMS Office of Inspector General, and the United States Justice Department. Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation may include participating in periodic Fraud and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

G. The Contractor shall ensure that the Department's toll-free Medical Assistance Provider Compliance Hotline number and accompanying explanatory statement is distributed to its Members and Providers through its Member and Provider handbooks. Notwithstanding this requirement, the Contractor is not required to reprint handbooks for the sole purpose of revising them to include Medical Assistance Provider Compliance Hotline information. The Contractor shall, however, include such information in any new version of these documents to be distributed to Members and Providers.

H. The Contractor may not knowingly have a Relationship with the following:

1. An individual who is barred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, 48 CFR Parts 1-51, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2. An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

"Relationship", for purposes of this section, is defined as follows:

1. A director, officer, or partner of the Contractor.
2. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

3. A person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement with the Department.

The Contractor shall immediately notify the Department, in writing, if a Provider or subcontractor with whom the Contractor has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the program as a result of suspected or confirmed Fraud or Abuse. The Contractor must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The Contractor must inform the Department, in writing, of the specific underlying conduct that lead to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements. Contractors who fail to report such information are subject to sanctions, penalties, or other actions.

The Contractor shall also notify the Department if it recovers overpayments or improper payments related to Fraud, Abuse or waste of Medical Assistance funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Provider, e.g. restricting the Members or services of a PCP.

- I. The Department will provide the Contractor with immediate notice via electronic transmission or access to Medichex listings or upon request if a Provider with whom the Contractor has entered into an agreement is subsequently suspended or terminated from participation in the Medicaid or Medicare Program. Such notification will not include the basis for the departmental action, due to confidentiality issues. Upon notification from the Department that a Provider with whom the Contractor has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, the Contractor shall immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the effective date of the Department's action.
- J. The Department may impose sanctions, penalties, or take other actions if it determines that the Contractor, Network Provider,

employee, or subcontractor has committed "Fraud" or "Abuse" as defined in this Agreement or has otherwise violated applicable law.

- K. The Contractor shall require that all Network Providers and all subcontractors take such actions as necessary to permit the Contractor to comply with the Fraud and Abuse requirements in this Agreement. The Contractor shall comply with Medical Assistance Regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.

#### **9.10 Conflict of Interest**

- A. The Contractor hereby assures that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with its performance under this Agreement and that in the performance of this Agreement, it shall not knowingly employ any person having such interest.
- B. The Contractor hereby assures that no member of its Governing Body or any of its officers or directors currently has or shall acquire any interest, direct or indirect, which would conflict in any manner or degree with the Contractor's performance under this Agreement.

#### **9.11 Reporting Ownership and Controlling Interest**

The Contractor shall notify the Department of any person or corporation that has five percent (5%) or more ownership or controlling interest in the Contractor's Plan.

#### **9.12 Other Federal Requirements**

- A. Contracts, subcontracts, and subgrants of amounts in excess of \$100,000 shall contain a provision, which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC § 1857(h)), section 508 of the Clean Water Act (33 USC § 1368), Executive Order 1178, and Environmental Protection Agency regulations (40 CFR part 15).



- B. The Contractor shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).
- C. The Contractor shall be in compliance with Equal Employment Opportunity (EEO) provisions.
- D. All contracts in excess of \$2,000 shall be in compliance with the Copeland Anti-Kickback Act and the Davis-Bacon Act.
- E. All contracts in excess of \$2,000 for construction and \$2,500 employing mechanics or laborers shall abide by and be in compliance with the Contract Work Hours and Safety Standards.
- F. The Contractor shall comply with the Byrd Anti-Lobbying Amendment. The Contractor may not use Federal funds for lobbying, and shall certify this to the Department or CMS upon request.

## **ARTICLE X: REPORTS**

### **10.1 Reporting Requirements**

The Contractor shall submit the following reports to the Department by the specified deadlines and in the formats set forth by the Department, including electronic transmission of data. The Contractor shall, in addition, participate both financially and programmatically in any data collection or survey activities for which the Department requests the Contractor's participation. The Contractor shall make all collected data available to the Department and upon request to CMS. All reports and data submitted shall be accompanied by a written certification of the Executive Director that attests, based on the Executive Director's knowledge and information, to the accuracy, completeness and truthfulness of the documents and data.

#### **A. Financial Reports**

The Contractor shall submit financial reports specified in this Section to the Department in the frequency, format and detail prescribed by the Department based on the Department's fiscal

year (July 1 through June 30). Administrative start-up and development costs shall be specifically and separately identified. Reports and reporting frequency may be modified by the Department.

1. Quarterly Budgeted vs. Actual Financial Report due within forty-five (45) days of the end of each quarter (see Attachment III).
2. Annual Financial Statement due within one- hundred eighty (180) days of the end of the year.
3. Annual Financial Statements of Related Entities within one- hundred eighty (180) days of the end of the year.
4. Entity-wide Annual Audit (including related party disclosure) within one hundred eighty (180) days of the end of the year being audited.

B. Quarterly Reports (Due within thirty (30) days of end of each quarter)

1. Enrollment Report, which includes:
  - a. The number of referrals received from BAS
  - b. The number of Team evaluations completed
  - c. The number of Applicants determined ineligible for ACAP (broken out by reason for denial)
  - d. The number of Applicants determined eligible for ACAP
  - e. The number of Participants enrolled in ACAP
  - f. The number of Applicants choosing to not enroll (include reason)
  - g. The number of voluntary disenrollments (attach discharge summaries)

- h. The number of involuntary disenrollments (attach discharge summaries)
  - i. The number of Participant deaths
  - j. The number of total Participants
2. Complaint/Grievance Report, which includes:
- a. The number of Complaints received
  - b. The number of Complaints resolved
  - c. The number of Grievances received
  - d. The number of Grievances resolved
3. Third Party Liability (TPL) Report, which includes:
- a. the number of times Participants have gained, lost, or changed TPL coverage including date information was faxed to Department
  - b. the number of TPL recoveries (attach documentation)
  - c. the amount of money recovered
  - d. the number of possible TPL tort cases (attach documentation)
4. Services Report, which includes:
- a. Network Provider characteristics including zip code of location, number of Participants served, total encounters year to date, and number of complaints year to date.
  - b. Non-Network Provider characteristics including zip code of location, number of Participants served, total

encounters year to date, and number of complaints year to date.

c. Services furnished to Participants.

The Contractor shall ensure that data received from Network Providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.

C. Ad Hoc Reports

The Contractor shall provide any additional information that the Department needs as determined necessary by the Department or to substantiate the above reports, or monitor effectiveness of the Plan.

## **10.2 Completion of Assessment Instrument**

At the Department's direction, the Contractor shall use an assessment instrument(s) designated by the Department, to complete an assessment on a regular basis (as determined by the Department) for each Participant for the purpose of comparing the ACAP population to the ICF/MR, ICF/ORC, and waiver populations. The Contractor shall transmit the results of the assessments to the Department or its designee in an electronic format specified by the Department. The Contractor shall purchase the software required to transmit the data and attend any training needed in order to comply with this requirement.

## **10.3 Consumer Satisfaction Surveys**

The Contractor shall regularly evaluate Participants' satisfaction with services and shall facilitate implementation of such consumer satisfaction surveys (from Participant and caregiver) as the Department determines are necessary in order to evaluate services provided under this Agreement.

## **ARTICLE XI: TERMINATION OF AGREEMENT**

### **11.1 Failure to Conform**

In the event of the Contractor's failure to conform to the requirements set forth in Section 8.1, the Department may terminate this Agreement upon thirty (30) days written notice in accordance with Section 11.3.A.

### **11.2 Termination Without Notice**

The Department may terminate this Agreement immediately upon any of the following events:

- A. The Contractor's:
  - 1. Application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;
  - 2. Admission in writing that it is unable to pay its debts as they mature;
  - 3. Assignment for the benefit of creditors; or
  - 4. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceedings.
- B. Commencement of an involuntary proceeding against the Contractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within sixty (60) days.
- C. The Contractor loses of any of the following:
  - 1. Licensure at any of the Contractor's facilities;
  - 2. Any federally required certification(s); or
  - 3. State or federal approvals of the Contractor.

- D. Cessation of state or federal funding of Title XIX programs, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases.

### **11.3 Termination With Notice**

Either party may terminate this Agreement upon any of the following events:

- A. Breach by a party of any duty or obligation under this Agreement which breach continues unremedied for thirty (30) days after written notice thereof by the other party.
- B. Written notice by one party to the other of its intent to terminate this Agreement within one hundred and twenty (120) days of such notice.

### **11.4 Continuance of Contractor's Obligations at Termination**

- A. Notwithstanding the termination of this Agreement for any reason, including insolvency, the Contractor's obligations to each Participant at the time of such termination shall continue in effect until the Contractor finds other services for the Participant.
- B. Upon termination of this Agreement for any reason, all finished or unfinished documents, data, studies and reports prepared by the Contractor under this Agreement shall become the property of the Department.
- C. Upon termination of this Agreement for any reason, the Contractor shall cooperate with the Department in the development and implementation of a transition plan.

### **11.5 Responsibilities**

In the event that this Agreement is terminated or is not renewed for any reason:

- A. The Contractor shall be responsible for notifying all Participants in writing within five (5) days of the Department's notice of

termination or non-renewal of this agreement of the date of termination and the process by which those Participants will continue to receive Covered Services;

- B. The Contractor shall promptly return any payments advanced to the Contractor for periods after the effective date of termination;
- C. The Contractor shall provide Participants with copies of their medical records including assessment scores according to the timeframe stated in the Department's notice of termination or non-renewal of this Agreement; and
- D. The Contractor shall promptly supply all information to the Department necessary for the reimbursement of any outstanding Medical Assistance Program claims.

## **ARTICLE XII: EFFECTIVE TERM, RENEGOTIATION, AND MODIFICATION**

### **12.1 Effectiveness of Agreement**

- A. This Agreement is subject to:
  - 1. Availability of federal and state funds appropriated by the Commonwealth of Pennsylvania and certified by the Comptroller each fiscal year (July 1-June 30) that are necessary to discharge the Department's payment obligations under this Agreement, and
  - 2. Approval of state officials as required by statute, regulation or administrative order.

In the absence of such appropriation and certification in any fiscal year, or in the event such funding is withdrawn from the Commonwealth for any reason, this Agreement shall be terminated without Department liability for damages, penalties or other charges on account of early termination, but without prejudice to such rights and obligations as may have accrued prior to such subsequent fiscal year.

- B. The Contractor may not enroll Participants until it receives written verification from the Department that it has met the requirements of the Department's readiness review process.

## **12.2 Term of Agreement**

This Agreement will continue for a period of one year from the effective date and will be extended for subsequent years in the absence of a notice by the Department to the Contractor to terminate or not renew the Agreement.

## **12.3 Renegotiation**

Renegotiation of this Agreement may commence at any time. The Contractor shall supply the Department with any information necessary to assess the Contractor's performance under this Agreement and the appropriateness of the Capitation Payments.

## **12.4 Amendments**

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors in this Agreement. By mutual consent, the parties may amend this Agreement where such amendment does not violate state or federal laws, regulations, or waiver requirements provided that such amendment is in writing, signed by both parties, and attached to this Agreement.

## **12.5 Sanctions**

- A. The Department may apply sanctions to the Contractor for noncompliance with or nonperformance or unsatisfactory performance of the terms of this Agreement or noncompliance with applicable state and federal law and regulations.
- B. The Department will give the Contractor ten (10) days advance written notice before it applies sanctions to the Contractor for noncompliance with or nonperformance or unsatisfactory performance of the terms of this Agreement or noncompliance with applicable state and federal law and regulations.
- C. The following sanctions may be applied at the discretion of the Department for non-compliance with or non-performance or



unsatisfactory performance under this Agreement as determined by the Department:

1. A warning that future noncompliance with or nonperformance or unsatisfactory performance under this Agreement will result in actions such as those as stated in 2, 3, and 4 of this paragraph.
2. Withholding all or part of the Capitation Payments.
3. Suspension of new enrollment or restriction of current enrollment.
4. Fines or penalties consistent with those applied to nursing facilities or ICFs/MR in the Commonwealth.

## **12.6 Notices**

Notices to the parties as to any matter for which notice is required under this Agreement will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered by hand to:

For the Contractor:

President and CEO  
Keystone Autism Services  
124 Pine Street  
Harrisburg, PA 17101

For the Department:

Commonwealth of Pennsylvania  
Department of Public Welfare  
Bureau of Autism - ACAP  
P.O. Box 2675  
Harrisburg, PA 17105-2675

IN WITNESS HEREOF, the parties have caused this Agreement to be executed under Seal by their duly authorized officers or representatives as of the day and year stated:

The Contractor

Commonwealth of Pennsylvania  
Department of Public Welfare

\_\_\_\_\_  
By: \_\_\_\_\_  
(Signature)

By: \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Official Title)

Title: Deputy Secretary  
Office of Developmental Programs

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)