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HealthChoices Behavioral Health Definitions

ACCESS PLUS – The Medical Assistance physical health care delivery system which is an Enhanced Primary Care Case Management and Disease Management Program providing services to eligible MA recipients not enrolled in a voluntary managed care organization in the 42 counties where HealthChoices Physical Health Mandatory Managed Care is not operational.

Adjudicate - A determination to pay or reject a claim.

Affiliate - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a Private Sector BH-MCO, including a Private Sector BH-MCO subcontracting with a county, Joinder, or a Private Sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the Private Sector BH-MCO's or Private Sector BH-MCO's parent(s), directors and subsidiaries of the Private Sector BH-MCO, shall be presumed to be Affiliates for purposes of this Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement – The HealthChoices Behavioral Health Agreement.

Alternative Payment Arrangement (APA) – refers to any of the various contractual agreements for reimbursement that are not based on a traditional fee for service model. Types of arrangements include, but are not limited to the following: retainer payments; case rates; and subcapitation.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of Behavioral Health Services under this Agreement.

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

Behavioral Health Residential Treatment Facility – An In-Plan Services mental health or drug and alcohol residential treatment facility.
Behavioral Health Services – Services that are provided to Members to treat mental health and/or substance abuse diagnoses/disorders.

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

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

Capitation - A fee the Department pays periodically to a Primary Contractor for each Member enrolled under an agreement for the provision of covered In-Plan Services, whether or not the Member received the services during the period covered by the fee.

Care Management/Manager - see Service Management/Manager.

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

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

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

Co-Occurring Disorder Professional – An individual who is certified by a state or national certification body to provide integrated co-occurring psychiatric and substance use treatment, or trained in a recognized discipline, including but not limited to psychiatry, psychology, social work, or addictions, and has one year of clinical experience in the treatment of co-occurring disorders.

Complaint – A dispute or objection filed with the BH-MCO regarding a participating health care Provider or the coverage, operations, or management policies of a BH-MCO, including, but not limited to, 1) a denial because the requested service is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a Complaint or Grievance within the specified timeframes; 4) a denial of payment after a
service(s) has been delivered because the service was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit. The term does not include a Grievance.

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

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

**County Operated BH-MCO** - An entity organized and directly operated by county government to manage the purchase and provision of Behavioral Health Services under the HealthChoices Program as a Primary Contractor.

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

**Day** – A calendar day unless otherwise specified in the Agreement.

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

**Denial of Services** - A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

- disapproves the request completely, or
- approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
- disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
- reduces, suspends, or terminates a previously authorized service.
Note: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

i) The service requested is not a covered service.
ii) The service requested is a covered service but not for this particular recipient (due to age, etc.)
iii) The information provided is insufficient to determine that the service is medically necessary.
iv) The service requested is not medically necessary.

Department/DPW - The Pennsylvania Department of Public Welfare.

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

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

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

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

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

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

Emergency Services - Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services under the Medical Assistance Program and which are needed to evaluate or stabilize an Emergency Medical Condition.
**Enrollment Assistance Program (EAP)** - The program responsible to assist MA recipients in enrolling in the HC Program, including the selection of a PH-MCO and Primary Care Practitioner, and obtaining information regarding the HC physical and behavioral health programs.

**Enrollment Specialist** - The EAP individual who will be responsible to assist recipients with selecting a PH-MCO and Primary Care Practitioner, and providing information about the HealthChoices PH and BH programs.

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

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

**Federally Qualified Health Clinic (FQHC)/ Rural Health Clinic (RHC)** – An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(1) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under 42 U.S.C.A. 1396d(1).

**Grievance** - A request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or in part, payment for a service if based on lack of Medical Necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service.

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

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

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

**HealthChoices Behavioral Health (HC-BH) Program** – The mandatory managed care program which provides Medical Assistance recipients with Behavioral Health Services in the Commonwealth.
HealthChoices Physical Health (HC-PH) Program – The mandatory managed care program which provides Medical Assistance recipients with physical health services in the Commonwealth.


HealthChoices Zone (HC Zone) – County groupings designated by the Department for participation in the HC-BH Program.

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

In-Plan Services - Services which are included in the HC-BH Capitation rate and are the payment responsibility of the Primary Contractor.

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

Joinder - Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and mental retardation program, subject to the provisions of the Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4201 (2)), or a drug and alcohol program pursuant to the Pa. Drug and Alcohol Abuse Control Act (71 P.S. § 1690. 101 et. seq.).
**Juvenile Detention Center** - A publicly or privately administered, secure residential placement for:

- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;

- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and

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

**Managed Care Organization (MCO)** - An entity which manages the purchase and provision of physical or Behavioral Health Services under the HC Program.

**MCO Assessment** – an assessment imposed upon the revenues of DPW’s Medicaid managed care organizations pursuant to 62 P.S. §801-B et seq.

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

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

**Member (Enrollee)** - A Medicaid or Medical Assistance recipient who is currently enrolled in the HC-BH Program.

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

**Mental Health Professional** - A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, and nursing who has a graduate degree and mental health clinical experience, or a Registered Nurse with at least two years of mental health clinical experience.
Minority Business Enterprise (MBE) - A business concern which is: a sole proprietorship, owned and controlled by a minority; a partnership or joint venture controlled by minorities in which 51% of the beneficial ownership interest is held by minorities; or a corporation or other entity controlled by minorities in which 51% of the voting interest and 51% of the beneficial ownership interest are held by minorities.

Multi-County Entity – Two or more counties which form a legally binding incorporated entity, such as a 501c (3), which has established Articles of Incorporation and intergovernmental agreements and has a single Agreement with the Department. This entity is established for the purpose of offering Behavioral Health Services for Medicaid eligible recipients under the HealthChoices Program as a Primary Contractor.

On-Site Reviews- A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor and a BH-MCO contractor to accept Members and to manage and administer the purchase and provision of Behavioral Health Services under this Agreement.

Out-of-Area Services - In-Plan Services provided to a Member while the Member is outside the HealthChoices Zone.

Out-of-Network Provider - A Behavioral Health Services Provider who does not have a written Provider Agreement with the BH-MCO and is therefore not included or identified as being in the BH-MCO's Provider network.

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

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

Physical Health Service System (PHSS) - any system by which a Medical Assistance recipient receives physical health services (e.g. Fee for Service; HealthChoices Physical Health; voluntary MCOs and ACCESS Plus).

Preferred Provider Organization (PPO) - A Commonwealth licensed person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred Provider arrangement, as defined in 31 Pa. Code Subsection 152.2.
Prepaid Inpatient Health Plan (PIHP) - An entity that provides medical services to enrolled recipients, under contract with the Medicaid agency and on the basis of prepaid Capitation fees, but is not subject to requirements in Section 1903(m)(2)(A) of Title XIX of the Social Security Act.

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

Primary Contractor - A county, Multi-County Entity or a BH-MCO which has a HealthChoices Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

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

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

Prior Authorized Services - In-Plan Services for which a BH services Provider must obtain, pursuant to Department approved BH-MCO policies and procedures, the BH-MCO's approval in advance of the Provider's initiating provision of the service.

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

Private Sector BH-MCO - A Commonwealth licensed BH-MCO which has contracted with the Department or county government to manage the purchase and provision of Behavioral Health Services under this Agreement.
PROMISe- (Provider Reimbursement and Operations Management Information System) is the HIPAA-compliant claims processing and management information system implemented by the Department in March 2004.

Provider – An individual, firm, corporation, or other entity which provides behavioral health or medical services or supplies to Medical Assistance recipients.

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

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

Reinvestment Funds - Capitation revenues from DPW and investment income which are not expended during an Agreement period by the Primary Contractor for purchase of services for Members, administrative costs, Risk and Contingency Funds, and equity requirements but may be used in a subsequent Agreement period to purchase start-up costs for In-Plan Services, development or purchase of Supplemental Services or non-medical services, contingent upon DPW prior approval of the Primary Contractor’s reinvestment plan.

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

1. Performs some of the Primary Contractor or its BH-MCO's management functions under contract or delegation; or

2. Furnishes services to Members under a written agreement; or

3. Leases real property or sells materials to the Primary Contractor or its BH-MCO at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

Retrospective Review - A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO's payment policies and procedures.
**Risk and Contingency Funds** – Capitation payments received by the Primary Contractor pursuant to the Agreement, which are not expended on services (In-Plan, Supplemental, or cost effective alternatives) or administrative functions and which are in excess of the Equity Reserve required to be maintained under the Agreement. Risk and Contingency Funds do not include Reinvestment Funds, or funds designated in a reinvestment plan submitted to DPW.

**Risk Assuming PPO** - A Commonwealth licensed PPO which meets the definition of a Risk Assuming PPO pursuant to regulations at 31 Pa. Code Subsection 152.2.

**Rural** - Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons, as defined by the US Census Bureau.

**Service Management/Manager** - The BH-MCO function/staff with responsibility to authorize and coordinate the provision of In-Plan Services. Care Management/Manager is synonymous.

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

**Start Date** - The first date on which Members are eligible for Behavioral Health Services under the Agreement, and on which the Primary Contractor is at risk for providing Behavioral Health Services to Members.

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

**Subcontractor** – Any person other than the Primary Contractor or its BH-MCO who enters into a Subcontract.

**Supplemental Services** – MA eligible mental health and drug and alcohol services purchased in lieu of or in addition to an In-Plan Service.

**Third Party Liability (TPL)** – Any individual, entity, (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Member’s health care expenses.

**Title XVIII (Medicare)** - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD)

**COMMONWEALTH OF PENNSYLVANIA**
**HealthChoices Behavioral Health Program**
**Program Standards and Requirements - Primary Contractor**
**July 1, 2009**
Urban - Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more, as defined by the US Census Bureau. These places must be in close geographic proximity to one another.

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

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

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

Women’s Business Enterprise- A small business concern which is: a sole proprietorship, owned and controlled by a woman; a partnership or joint venture controlled by women in which at least 51% of the beneficial ownership interest is held by women; or a corporation or other entity controlled by women in which at least 51% of the voting interest and 51% of the beneficial ownership interest is held by women.
# ACRONYMS

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<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>AFDC</td>
<td>Aid to Families with Dependent Children</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APA</td>
<td>Alternative Payment Arrangement</td>
</tr>
<tr>
<td>APD</td>
<td>Advanced Planning Document</td>
</tr>
<tr>
<td>ARD</td>
<td>Accelerated Rehabilitation Decision</td>
</tr>
<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>ASCII</td>
<td>American Standard Code for Information Interchange</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>BDAP</td>
<td>Bureau of Drug and Alcohol Programs</td>
</tr>
<tr>
<td>BDAP CIS</td>
<td>Bureau of Drug and Alcohol Programs’ Client Information System</td>
</tr>
<tr>
<td>BEC</td>
<td>Basic Education Circular</td>
</tr>
<tr>
<td>BHEF</td>
<td>Behavioral Health Encounter File</td>
</tr>
<tr>
<td>BH-MCO</td>
<td>Behavioral Health Managed Care Organization</td>
</tr>
<tr>
<td>BHRS</td>
<td>Behavioral Health Rehabilitation Services for Children and Adolescents</td>
</tr>
<tr>
<td>BNDD</td>
<td>Bureau of Narcotic Drugs and Devices</td>
</tr>
<tr>
<td>BSU</td>
<td>Base Service Unit</td>
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<tr>
<td>BMWBO</td>
<td>Bureau of Minority and Women Business Opportunities</td>
</tr>
<tr>
<td>C&amp;Y</td>
<td>Children and Youth</td>
</tr>
<tr>
<td>CAO</td>
<td>County Assistance Office</td>
</tr>
</tbody>
</table>

COMMONWEALTH OF PENNSYLVANIA
HealthChoices Behavioral Health Program
Program Standards and Requirements - Primary Contractor
July 1, 2009
CASSP  Child and Adolescent Service System Program
CAU    County Administrative Unit
CCRS   Consolidated Community Reporting System
CCYA   County Children and Youth Agency
CFO    Chief Financial Officer
CFR    Code of Federal Regulations
C/FST  Consumer/Family Satisfaction Team
CHADD  Children with Attention Deficit Disorders
CIS    Client Information System
CISC   Children and Adolescents in Substitute Care
CLIA   Clinical Laboratory Improvement Amendment
CMS    Centers for Medicare and Medicaid Services
COB    Coordination of Benefits
CQI    Continuous Quality Improvement
CRD/LIC Credentials/license
CRCS   Capitation Rate Calculation Sheet
CRF    Consumer Registry File
CRNP   Certified Registered Nurse Practitioner
CRR    Community Residential Rehabilitation
CSI    Consumer Satisfaction Instruments
CSP    Community Support Program
<table>
<thead>
<tr>
<th>CST</th>
<th>Consumer Satisfaction Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAP</td>
<td>Disability Advocacy Program</td>
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<tr>
<td>D&amp;A</td>
<td>Drug and Alcohol</td>
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<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
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<tr>
<td>DHHS</td>
<td>U.S. Department of Health and Human Services</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>DMIRS</td>
<td>Data Management and Information Retrieval System</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DPW</td>
<td>Department of Public Welfare</td>
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<tr>
<td>DSH</td>
<td>Disproportionate Share</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual</td>
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<tr>
<td>DUR</td>
<td>Drug Utilization Review</td>
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<td>EAP</td>
<td>Enrollment Assistance Program</td>
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<td>ECC</td>
<td>Electronic Claims Capture</td>
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<td>ECM</td>
<td>Electronic Claims Management</td>
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<td>EIN</td>
<td>Employee Identification Number</td>
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<tr>
<td>EMC</td>
<td>Electronic Media Claims</td>
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<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis and Treatment</td>
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<tr>
<td>EQRO</td>
<td>External Quality Review Organization</td>
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<tr>
<td>ER</td>
<td>Emergency Room</td>
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<tr>
<td>ERISA</td>
<td>Employee Retirement Income Security Act, 1974</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>EVS</td>
<td>Eligibility Verification System</td>
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<tr>
<td>FA</td>
<td>Fiscal Agent</td>
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<td>Family Based Mental Health Services</td>
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<td>FFS</td>
<td>Fee-For-Service</td>
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<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<td>FRR</td>
<td>Financial Reporting Requirements</td>
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<td>FST</td>
<td>Family Satisfaction Team</td>
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<td>Full Time Equivalent</td>
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<td>File Transfer Process</td>
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<td>General Assistance</td>
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<td>GAAP</td>
<td>Generally Accepted Accounting Principles</td>
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<td>Graduate Medical Education</td>
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<td>HC</td>
<td>HealthChoices</td>
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<td>Health Care Quality Unit</td>
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<td>HCPCS</td>
<td>CMS Common Procedure Coding System</td>
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<td>HealthChoices Lehigh/Capital</td>
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<td>HC-SW</td>
<td>HealthChoices - Southwest</td>
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<tr>
<td>HEDIS</td>
<td>Health Plan Employer Data and Information Set Standards</td>
</tr>
</tbody>
</table>

**COMMONWEALTH OF PENNSYLVANIA**

HealthChoices Behavioral Health Program

Program Standards and Requirements - Primary Contractor

July 1, 2009
HIPAA Health Insurance Portability and Accountability Act
HIO Health Insuring Organizations
HIV/AIDS Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HMO Health Maintenance Organization
IBNR Incurred But Not Reported Claims
ICD International Classification of Diseases
ICF Intermediate Care Facility
ICF/MR Intermediate Care Facilities for Persons With Mental Retardation
ID Insurance Department
IFB Invitation for Bid
IMD Institutions For Mental Disease
ISP Individualized Service Plan
JDC Juvenile Detention Center
JPO Juvenile Probation Office
L/C Lehigh/Capital
LTC Long Term Care
MA Medical Assistance
MAID Medical Assistance Identification Number
MATP Medical Assistance Transportation Program
MBE Minority Business Enterprise
MBE/WBE Minority Business Enterprise/Women Business Enterprise
MCO  Managed Care Organization
MIS  Management Information System
MR  Mental Retardation
MOE  Method of Evaluation
MPL  Minimum Participating Levels
NCQA  National Committee for Quality Assurance
NDC  National Drug Code
NCE  Non-Continuous Eligibility
NMP  Non-money payment
OBRA  Omnibus Budget Reconciliation Act
OCYF  Office of Children, Youth & Families
OIP  Other Insurance Paid
OMAP  Office of Medical Assistance Programs
OMHSAS  Office of Mental Health and Substance Abuse Services
OMR  Office of Mental Retardation
ORC  Other Related Conditions
OSP  Office of Social Programs
OTC  Over The Counter
PCIS  Patient Census Information System
PCP  Primary Care Practitioner
PCPC  Pennsylvania Client Placement Criteria
PDA  Pennsylvania Department of Aging
PH-MCO  Physical Health Managed Care Organization
PHSS  Physical Health Service System
PIHP  Prepaid Inpatient Health Plan
PIN  Parents Involved Network
PMPM  Per Member Per Month
POM  Performance Outcome Measures
POMS  Performance Outcome Management System
POSNet  Pennsylvania Open Systems Network
PPO  Preferred Provider Organization
PROMISe  Provider Reimbursement and Operations Management Information System electronic
PRTF  Psychiatric Residential Treatment Facility
QARI  Quality Assurance Reform Initiative
QM  Quality Management
QMB  Qualified Medicare Beneficiaries
QSF  Quarterly Status File
RBUC  Received But Unpaid Claims
RFP  Request For Proposal
RHC  Rural Health Clinic
RTF  Residential Treatment Facility
SAP Statutory Accounting Principles
SBP State Blind Pension
SCA Single County Authority
SE Southeast
SMH State Mental Hospital
SMM State Medicaid Manual
SNF Skilled Nursing Facility
SNU Special Needs Unit
SPR System Performance Review
SSA Social Security Administration
SSI Supplemental Security Income
SSN Social Security Number
SUR Surveillance and Utilization Review
SURS Surveillance and Utilization Review System
SW Southwest
TANF Temporary Assistance to Needy Families
TPL Third Party Liability
TTY Text Telephone Typewriter
UM Utilization Management
UM/QM Utilization Management/Quality Management
UPIN Unique Physician Identification Number

COMMONWEALTH OF PENNSYLVANIA
HealthChoices Behavioral Health Program
Program Standards and Requirements - Primary Contractor
July 1, 2009
PART I. GENERAL INFORMATION

I-1. PURPOSE

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

The purpose of this document is to set forth the standards and requirements for the HC-BH Program operating under the Centers for Medicare and Medicaid Services (CMS) Waiver of Section 1915(b) of the Social Security Act, through counties that are Primary Contractors.

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

I-2. ISSUING OFFICE

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

I-3. SCOPE

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

A county is the smallest geographic unit for which the Department enters into a HealthChoices behavioral health contract, and the Primary Contractor must be capable of delivering specified services to all Members in the county. A Multi-County Entity must identify an entity as the Primary Contractor. The Department will contract with this entity and conduct all business through this entity.
I-4. **TYPE of AGREEMENT**

The Department enters into a full-risk prepaid capitated contract using a flat fee per Member in the counties. The Primary Contractor is responsible for all medically necessary In-Plan Services. Should the Primary Contractor incur costs which exceed the Capitation payments, the Department is not responsible for providing additional funds to cover the deficits. The method of payment is monthly. Negotiations may be undertaken with qualified vendors demonstrating qualifications, responsibility, and capability for performing the contract work as to price and other factors.

Primary Contractors assume risk for providing services to Members upon the effective date of the Agreement. Subject to the availability of state and federal funds, the Department reserves the right to renew the Agreement for additional periods. The Department will notify the Primary Contractor of its intention to renew prior to the expiration of the Agreement.

The Department has the option of entering into a single contract covering all of the counties covered by a Multi-County Entity. In the event of a Multi-County Entity submitting a single proposal, an entity must be identified as the Primary Contractor. The Department will conduct all business through this entity. Under a multi-county arrangement, each county in the Multi-County Entity will be required to sign one contract with the Department. In addition, one multi-county Capitation rate for each rating group will be developed covering all of the counties in the Multi-County Entity. Risk for one county may not be assumed by another county or counties in the Multi-County Entity. In its contract with the Department, the Multi-County Entity would be held to the same HC-BH Program requirements as counties entering into individual county contracts with the Department. The participating counties will not be required to be contiguous and the Department will permit Multi-County Entities consisting of counties in different HealthChoices Zones. A re-procurement will occur for any county that withdraws from the Multi-County Entity. DPW will select a private sector BH-MCO as a Primary Contractor for that county. The remaining county(ies) in a Multi-County Entity must continue to meet the Department’s requirements.

In addition to the multi-county contracting option and in order to ensure efficiency in administrative costs, the Department requires HealthChoices Behavioral Health contractors to cover a minimum of 10,000 HealthChoices Members as follows:

- An individual county with less than 10,000 HealthChoices Members that contracts directly with the Department must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members. The Members covered by the BH-MCO may be from other HealthChoices counties or other HealthChoices Zones.
- A Multi-County Entity that chooses to jointly contract with the Department must cover at least 10,000 HealthChoices Members or must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members.
Requirements of this document are part of the Agreement and are not subject to negotiation by the Primary Contractor. The Department will develop a transition plan should it choose to cancel or not extend a contract with one or more Primary Contractors operating the behavioral health program.

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or Waiver approvals, or change in applicable federal or Commonwealth law, regulations, public policy, or at the convenience of the Department. A Primary Contractor and its BH-MCO must be able to provide services to all Members residing within the county or counties that it proposes to serve.

I-5. ON-SITE REVIEWS

The Department periodically conducts On-Site Reviews of selected Primary Contractors and its BH-MCO. The purpose of an On-Site Review is to determine a Primary Contractor and its BH-MCO's initial and ongoing compliance with respect to meeting work statement tasks and program, standards and requirements. The Department reserves the right to suspend implementation of the Agreement and/or Member enrollment for any Primary Contractor or its BH-MCO that does not demonstrate to the Department's satisfaction, compliance with any critical program standard.

I-6. INCURRING COSTS

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

I-7. HEALTHCHOICES RATE INFORMATION

The Department releases historical cost data by rating group and category of service for the various HealthChoices Zones. Additional data and/or information may also be provided to assist the Primary Contractor in constructing or responding to a Capitation rate proposal.

I-8. HEALTHCHOICES LIBRARY

Documents relevant to the HealthChoices program are available for review in the HealthChoices Library at the Office of Mental Health and Substance Abuse Services, DGS Annex Complex, Beechmont Building, 112 East Azalea Drive, Harrisburg, PA 17110. The documents available from the Department include but are not limited to those documents listed in Appendix DD.
I-9. RESPONSIBILITY TO EMPLOY WELFARE RECIPIENTS

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

I-10. DISADVANTAGED BUSINESS INFORMATION

The Commonwealth encourages participation by small disadvantaged businesses as prime contractors, joint ventures and Subcontractors/suppliers and by socially disadvantaged businesses as prime contractors.

Small Disadvantaged Businesses are small businesses that are owned or controlled by a majority of persons, not limited to members of minority groups, who have been deprived of the opportunity to develop and maintain a competitive position in the economy because of social disadvantages. The term includes: (1) Department of General Services Bureau of Minority and Women Business Opportunities (BMWBO)-certified Minority Businesses Enterprises (MBEs) and Women Business Enterprises (WBEs) that qualify as small businesses and (2) United States Small Business Administration-certified small disadvantaged businesses or 8(a) small disadvantaged business concerns.

Small businesses are businesses in the United States that are independently owned, are not dominant in their field of operation, employ no more than 100 persons and earn less than $20 million in gross annual revenues ($25 million in gross annual revenues for those businesses in the information technology sales or service business).

Socially disadvantaged businesses are businesses in the United States that BMWBO determines are owned or controlled by a majority of persons, not limited to members of minority groups, who are subject to racial or ethnic prejudice or cultural bias, but which do not qualify as small businesses. In order for a business to qualify as "socially disadvantaged", the proposer must include in its proposal clear and convincing evidence to establish that the business has personally suffered racial or ethnic prejudice or cultural bias stemming from the business person's color, ethnic origin or gender.

I-11. CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS

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

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

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

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

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

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

I-12. LOBBYING CERTIFICATION and DISCLOSURE

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant or cooperative agreement exceeding $100,000, or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. See Lobbying Certification Form and Disclosure of Lobbying Activities Form attached as Appendix D.

The Primary Contractor must complete and return the Lobbying Certification Form along with the signed Agreement.
I-13. CONTRACTOR’S CONFLICT OF INTEREST

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

I-14. PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES

The Primary Contractor and its BH-MCO may not knowingly have a relationship with the following:

A. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

B. An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (A) above.

For the purpose of this section, “relationship” means the following:

- A director, officer or partner of the Primary Contractor or its BH-MCO.
- A person with beneficial ownership of five percent (5%) or more of the BH-MCO’s equity.
- A person with employment, consulting or other arrangement with the Primary Contractor’s or its BH-MCO’s obligations under this Agreement.

I-15. INTEREST OF THE COMMONWEALTH AND OTHERS

No officer, member or employee of the Commonwealth and no member of the General Assembly, who exercises any functions or responsibilities under this Agreement, shall participate in any decision relating to this Agreement which affects his/her personal interest or the interest of any corporation, partnership or association in which he is, directly or indirectly, interested; nor shall any such officer, member or employee of the Commonwealth or member of its General Assembly have interest, direct or indirect, in this Agreement or the proceeds thereof.
I-16. PRIMARY CONTRACTOR RESPONSIBILITIES

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

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

Office space, equipment, and logistical support are the responsibility of the Primary Contractor. The BH-MCO's administrative offices, from which the program is operated, must be located in close geographic proximity to the county or counties in which In-Plan Services are provided.

I-17. FREEDOM OF INFORMATION AND PRIVACY ACTS

The Primary Contractor should be aware that all materials associated with this Agreement may be subjected to the terms of the Freedom of Information Act (5 U.S.C. Section 552 et seq.), the Privacy Act of 1974 (5 U.S.C. Section 552a), the Right-to-Know Law (65 P.S. Section 66.1 et seq.) and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, Health and Human Services (HHS), and Centers for Medicare and Medicaid Services (CMS).

I-18. NEWS RELEASES

News releases pertaining to this initiative will not be made without prior Commonwealth approval, and then only in coordination with the Department.
I-19. COMMONWEALTH PARTICIPATION

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

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

I-20. PROJECT MONITORING

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

In addition to Department oversight, CMS may also monitor the HC-BH Program through its regional office in Philadelphia, Pennsylvania, and its Office of Managed Care in Baltimore, Maryland.

I-21. CHANGES TO CERTAIN APPENDICES

The following Appendices may be updated, from time to time, by the Department through issuance of an operations memo, and/or policy clarification and does not require an amendment to this Agreement to be effective and enforceable:

- Appendix L: Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys
- Appendix P: The HealthChoices Behavioral Health Financial Reporting Requirements
- Appendix V: The HealthChoices Behavioral Health Recipient Coverage Document
- Appendix Y: The HealthChoices Behavioral Health Services Reporting Classification Chart
PART II. WORK STATEMENT – STANDARDS AND REQUIREMENTS

II-1. OVERVIEW

The goal of the HC-BH program is to improve the accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases. The Department intends to achieve these goals by enrolling eligible MA recipients in BH-MCOs which provide a specified scope of benefits to each enrolled Member in return for a capitated payment made on a PMPM basis.

II-2. OBJECTIVES

A. General

The Department is interested in working with counties and/or Private Sector BH-MCOs to administer the mandatory HC-BH Program within each county in the Commonwealth of Pennsylvania.

B. Specific Objectives

The HC-BH Program provides for the delivery of medically necessary mental health, drug and alcohol, and behavioral services. Specific objectives are:

1) Structure Objectives

a. To contract with each of the counties in the HealthChoices Zone, individually or in Multi-County Entities, to manage the purchase and provision of Behavioral Health Services in either one or more of the specified counties.

b. To provide county government the option to directly manage the program through a County Operated BH-MCO or to contract with a Private Sector BH-MCO. Such contracts do not relieve the county of ultimate responsibility for compliance with program and fiscal requirements, including program solvency. Counties may, however, include additional requirements and incentives in their contracts as needed to provide appropriate management oversight and flexibility in addressing local needs.

c. For counties not able to or not interested in contracting for the managed care program, the Department will contract with a Private Sector BH-MCO to directly manage the purchase and provision of Behavioral Health Services to Members.
2) Program Objectives

a. To promote resiliency-oriented and recovery-oriented best-practices that are cost effective.

b. To create systems of care management that are developed based on input from and responsive to the needs of consumers, persons in recovery, and their families representative of the various cultures and ethnic groups in the county, who depend on public services.

c. To provide incentives to implement Utilization Management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care, and increasing prevention and early diagnosis and treatment.

d. To promote partnerships between the public and private sectors that take advantage of the public sector's experience in serving persons with the most serious illnesses and disabilities who often have few resources and supports, and the private sector's expertise in managing financial risk for Behavioral Health Services.

e. To remove incentives to shift costs between behavioral health and other publicly funded human service and correctional programs.

f. To create geographic service areas of optimal size for managing risk under Capitation financing which allow for regional variations in program design and result in administrative cost savings.

g. To develop consumer and family satisfaction mechanisms in partnership with consumers, persons in recovery, and their families representative of the diverse ethnic, cultural and disability groups in the county who are affected by mental illness and addictive diseases.

h. To improve coordination of substance abuse and mental health services, including the development of specialized programs for persons with both psychiatric and substance abuse disorders.

i. To create new integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children and adolescents, including coordination with early intervention and early childhood care and education programs.
j. To shift the focus of state monitoring from process management to outcome management with an emphasis on reduction of out-of-home placements for children and adolescents, increased community tenure, improved health status, and improved vocational and educational functioning.

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

l. To improve coordination of care between physical and Behavioral Health Services including disease management, programs to improve health outcomes, educate consumers and Providers, and increase access to Providers.

II-3. Nature and Scope of the Project

The HealthChoices Program ensures that Members have access to quality physical and Behavioral Health Services while allowing the Commonwealth to stabilize the rate of growth in health care costs. Primary Contractors and their BH-MCOs for the behavioral health component of the HealthChoices Program are responsible for locating, coordinating, and monitoring the provision of designated Behavioral Health Services on behalf of Members.

A. Enrollment

1) HealthChoices Behavioral Health Care

Members are enrolled in the BH-MCO operating in their county of residence upon being determined eligible for Medical Assistance. As Members are enrolled, information will be forwarded to the BH-MCO. The BH-MCO must establish mechanisms to inform the County Assistance Office (CAO) of any change or update to the Member’s residency or eligibility status within 10 days of the date of learning of the change.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing Behavioral Health Services for newly enrolled Members. The Department will provide the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine periods of coverage and responsibility for services.
B. HealthChoices Program Eligible Groups

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

1) The eligible groups (see Appendix X for details) are:

a. Temporary Assistance to Needy Families (TANF) and TANF-Related MA: A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment), to families which contain dependent children who are deprived of the care or support of one or both Parents due to absence, incapacity, or unemployment of a parent.


c. Healthy Horizons: An MA program which provides non-money payment (NMP) MA and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. Exception: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC Program.

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

SSI without Medicare: Monthly cash payments made to persons who are aged, blind, or have been disabled for less than two years and will become eligible for Medicare when the disability has lasted for two years, under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.
e. **SSI-Related:** An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.

f. **State-Only GA:** A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

g. **Federally-Assisted MA for GA Recipients:** A federal and state funded program which provides MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

2) **Eligibility Determination**

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

3) **Guaranteed Eligibility**

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through the last day of the month in which the 60 days postpartum or post-loss of pregnancy period ends and their newborns are guaranteed coverage for one year, as long as mother and child continue to live together during that year.

4) **Involuntary Mental Health Commitment**

Whenever a Member residing in one HealthChoices county is made subject to involuntary examination and/or treatment in another HealthChoices county, the BH-MCO in the county in which the Member resides shall be responsible for the cost of examination and/or involuntary treatment provided in the other county. The BH-MCO providing services in the county in which the HealthChoices Member resides shall abide by the examination and/or involuntary treatment decisions made in the county in which services are rendered. The BH-MCO in the county where the Member receives examination and/or treatment shall notify the Member’s BH-MCO within twenty-four (24) hours of commitment.
5) Placement of Adults and Children NOT in Substitute Care in Behavioral Health Residential Treatment Facilities (see Appendix V – H.).

6) Children and Adolescents in Substitute Care Issues (see Appendix V – H.)

7) For children and adolescents placed in a juvenile detention facility, the BH-MCO is responsible for medically necessary In-Plan Services delivered in treatment settings outside (off site) the juvenile detention facility during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.

8) Children whose adoptions have been finalized and for whom the CCYA is continuing to provide support through an adoption assistance agreement with the adoptive Parents residing in the HC Zone are to be enrolled in the BH-MCO of the county where the adoptive family resides.

9) The BH-MCO will be required to pay for medically necessary Behavioral Health Services for Members provided within a private Intermediate Care Facility for persons with mental retardation (ICF/MR) facility within the HC Zone.

10) In order to serve an individual less than 21 years of age in a psychiatric hospital setting and be reimbursed through Medical Assistance for the services, the facility must be JCAHO accredited according to Federal Regulations, 42 CFR Subpart D §441 relating to Inpatient Psychiatric Facilities for an Individual Under age 21 in Psychiatric Facilities or Programs, at 42 CFR §441.151, General Requirements (a) (2).

C. Rating Period

A rating period coincides with the term of an Agreement period, i.e., the period for which Capitation rates are developed and instituted for each year of the Agreement. Capitation cost proposals apply to the initial rating period.

For the second and third rating periods, the Department will adjust Capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any or all of the following:
1) Changes in medical costs;

2) Changes in utilization patterns; or

3) Programmatic changes that affect the Primary Contractor and/or its BH-MCO's delivery or coverage of benefits.

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

If agreement is not reached prior to the start of an Agreement period, the rates applicable to the previous rating period will continue to apply until new rates are agreed upon and effective.

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

The Department reserves the right to expand or contract the scope of the HealthChoices Program during the term of the Agreement to include additional services or reduce services, or covered populations.

D. Termination/Cancellation

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

For Agreements with an individual county, DPW requires the Primary Contractor to provide a minimum of 120 days notice of intent to terminate the Agreement. For an Agreement with a Multi-County Entity, DPW requires a minimum of 180 days notice in the event the Primary Contractor intends to terminate the Agreement and also if one or more counties intend to withdraw from the Multi-County Entity during the Agreement period. The Agreement will remain in effect for the remaining counties who continue to meet Department requirements and the rates will be recalculated accordingly.
Upon termination/Cancellation or expiration of the Agreement, the Primary Contractor must:

1) Provide the Department with all information deemed necessary by the Department within 30 days of the request;

2) Be financially responsible for Provider claims with dates of service through the day of termination, except as provided in D.3) below, including those submitted within established time limits after the day of termination;

3) Be financially responsible for Members placed in inpatient and residential treatment facilities through the dates specified in Section E of the HC-BH Recipient Coverage Document (Appendix V).

4) Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in D.3) above, for which payment is denied by the BH-MCO and subsequently approved upon appeal by the Provider; and

5) Arrange for the orderly transition of Members and records to those Providers who will be assuming ongoing care for the Members.

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

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

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

F. False Claims

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

G. Major Disasters or Epidemics

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

H. Performance Standards and Damages

1) Performance Standards for the HC BH Program

Performance standards for the HC BH Program are included throughout this document. Additional standards may be developed for inclusion in subsequent related contracts. The Primary Contractor may develop performance standards consistent with this document. The Department reserves the right to institute incentive payments related to performance standards in the future.
2) Sanctions and Penalties

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

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

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

3) Profit, Discretionary Funds and Reinvestment Arrangement

a. Counties and Multi-County Entities as Primary Contractors and management or oversight entities formed by or organized on behalf of the counties or Multi-County Entities are not permitted to retain any Discretionary Funds. After the closure of each Agreement period, any county or Multi-County Entity’s Discretionary Funds which have not been included in a DPW approved reinvestment plan must be returned to DPW (Appendix N – Reinvestment Parameters).

b. BH-MCOs as Primary Contractors to DPW or Private Sector BH-MCOs as contractors to a county are permitted to retain profit in accordance with the terms of their contract with the Primary Contractor. Profit will be monitored by DPW and will be a factor in future DPW rate adjustments and negotiations with the Primary Contractor.

II-4. TASKS

A. In-Plan Services

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

1) The BH-MCO shall provide timely access to diagnostic, assessment, referral, and treatment services for Members for the following benefits:

a. Inpatient psychiatric hospital services, except when provided in a state mental hospital.
b. Inpatient drug and alcohol detoxification.

c. Psychiatric partial hospitalization services.

d. Inpatient drug and alcohol rehabilitation.

e. Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence.

f. Psychiatric outpatient clinic, licensed psychologist and psychiatrist services.

g. Behavioral health rehabilitation services (BHRS) for children and adolescents with psychiatric, substance abuse or mental retardation disorders.

h. MH residential treatment services for children and adolescents (accredited and non-accredited).

i. Outpatient D&A services, including Methadone Maintenance Clinic.

j. Methadone when used to treat narcotic/opioid dependency and dispensed by an In-Plan drug and alcohol services Provider.

k. Clozapine support services.

l. Laboratory and diagnostic studies and procedures for the purpose of determining response to behavioral health medication and/or treatment ordered by Behavioral Health Services Providers acting within the scope of their license.

m. Crisis intervention services (telephone and mobile with in-home capability).

n. Family-based mental health services for children and adolescents.

o. Targeted mental health case management (intensive case management and resource coordination).

p. Mobile Mental Health Treatment

q. Peer Support Services

r. Psychiatric Rehabilitation Services, contingent upon approval from CMS of a State Plan Amendment (Please Note: The Primary Contractor will be notified of the effective date when this service is approved by CMS)

s. Outpatient Drug and Alcohol Rehabilitation Services, contingent upon approval form CMS of a State Plan Amendment (Please Note: The Primary Contractor will be notified of the effective date when services are approved by CMS).

2) The Primary Contractor and its BH-MCO must require that network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service, if the Provider serves only Medicaid Members. Hours of operation should be flexible in order to accommodate the particular scheduling needs of Members (i.e. inclusion of evening and/or weekend hours).
3) The Primary Contractor or its BH-MCO must have procedures for authorization and payment for In-Plan Services, which are required but not available within the Provider network or for providing Emergency Services for Members who are temporarily out of the HealthChoices Zone.

a. A Primary Contractor or its BH-MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service, is not required to do so if the BH-MCO objects to the service on moral or religious grounds.

b. If the Primary Contractor or its BH-MCO elects not to provide, arrange for the provision of, or make payment for, a counseling or referral service because of an objection on moral or religious grounds, it must:
   • furnish information to the Department describing the service;
   • include this information with its application for a Medicaid contract;
   • notify the Department whenever it adopts the policy during the term of the Agreement;
   • notify Members within 30 days of adopting this policy and identify the excluded service(s); and,
   • be consistent with the provisions of 42 CFR 438.10.

4) Member Liability

a. Members will not be held liable for:

i) In-Plan Services provided to the Member for which the Department does not pay the Primary Contractor.

ii) In-Plan Services provided to the Member for which the Department does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.

iii) In-Plan Services to the extent that those payments are in excess of the amount that the Member would owe if the Primary Contractor or its BH-MCO provided the services directly.

b. In situations where a network Provider is not available to provide an In-Plan Service, the Primary Contractor and its BH-MCO must have procedures to coordinate with Out-of-Network Providers and must ensure that cost to the Members (if any) is no greater than it would be if the services were furnished by a network Provider.
5) The Primary Contractor or its BH-MCO is encouraged to develop and purchase cost effective Supplemental Services which can provide services in a less restrictive setting and/or which would result in improved outcomes for Members.

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

7) For Priority Populations, a clearly defined program of care which incorporates longitudinal and disease state management is expected. In addition, evidence of a coordinated approach must be demonstrated for those persons with co-existing mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with co-existing physical impairments, and other Special Needs Populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, persons diagnosed with ASD, persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities)

8) The Primary Contractor or its BH-MCO is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.
   a. There must be 24 hour capacity for service authorization.
   b. There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
   c. All Member and Provider calls must be answered within 30 seconds.
   d. Separate Member and Provider telephone lines are permitted.
   e. The Member line must be answered by a live voice at all times.
   f. BH-MCOs serving multiple counties in a HealthChoices Zone may establish a regional network with one telephone line for Member calls and one line for Provider calls.
   g. Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.
9) The Primary Contractor or its BH-MCO must have procedures for reminders, follow-up, and outreach to Members including:

a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.

b. Population groups with special needs and/or groups who under use needed Behavioral Health Services, such as older persons, persons who are homebound or homeless adults with mental retardation, and persons diagnosed with ASD.

c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

10) The Primary Contractor or its BH-MCO must have procedures to determine the EPSDT screen status for children receiving Behavioral Health Services. Referral to the child’s PH-MCO PCP must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The BH-MCO must have procedures to collect and report EPSDT screen referral and status information.

B. Coordination of Care

1) The BH-MCO and the PHSS, operating in the county(ies) covered by the BH-MCO, are required to develop and implement written agreements regarding the interaction and coordination of services provided to Members. These agreements must be submitted to and approved by the Department. A sample PH-BH coordination agreement (which does not include all required procedures) is in the HealthChoices Library. Complete agreements, including operational procedures, must be available for review by the Department at the time of On-Site Review. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the HC Program in a new HC Zone. The written agreements should include, but not be limited to:

a. Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services, and other treatment issues necessary for optimal health and prevention of illness or disease. The PHSS and the BH-MCO must collaborate in relation to the provision of Emergency Services; however, Emergency Services provided in general hospital emergency rooms are the responsibility of the Member's PHSS, regardless of the diagnosis or services provided. The only exception is for
emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis. Procedures must define and explain how payment will be shared when the Member's Primary Diagnosis changes during a continuous hospital stay.

b. Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the PHSS for Behavioral Health Services provided by the PHSS, or reimbursement by the PHSS to the BH-MCO for physical health services provided by the BH-MCO, and the resolution of any payment disputes for services rendered. Procedures must include provisions for assessment of persons with co-existing physical and behavioral health disorders, as well as provision for cost-sharing when both behavioral and physical health services are provided to a Member by a service Provider.

c. Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PHSS, the PCP, and BH and PH service Providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

d. Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.

e. Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources.

f. A mechanism for timely resolution of any clinical and fiscal payment disputes; including procedures for entering into binding arbitration to obtain final resolution.

g. Procedures for serving on Interagency Teams, as necessary.

h. Procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the BH-MCO service managers and/or service Provider(s) and the PHSS PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older Members with coexisting physical and behavioral health disorders such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and a serious mental illness or ASD).
i. The BH-MCO is required to provide behavioral health crisis intervention and other necessary In-Plan Services to Members with behavioral health Emergency Medical Conditions. The PHSS is responsible for payment of all emergency and medically necessary non-emergency ambulance services. The PHSS and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health Emergency Medical Conditions who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities.

j. Procedures for the coordination of laboratory services.

k. Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and Provider network with the PHSS special needs unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO Quality Management program and the PHSS Quality Management program.

l. Procedures for the PHSS to provide physical examinations required for the delivery of Behavioral Health Services, within designated timeframes for each service.

m. Procedures for the interaction and coordination of pharmacy services to include:

i) All pharmacy services are the payment responsibility of the Member’s PHSS. All prescribed medications are to be dispensed through PHSS network pharmacies. This includes drugs prescribed by both the PHSS and the Primary Contractor Providers. The only exception is that the Primary Contractor is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by Primary Contractor service Providers;

ii) Neither the PHSS nor the Primary Contractor is billed for medications administered during the course of an inpatient stay. Inpatient rates include the cost of all pharmaceuticals. Hospital inpatient rates are calculated to include ancillary costs, which are included in the per diem. Medications dispensed on an inpatient unit are an ancillary cost.
The PHSS may only restrict pharmacy services prescribed by a BH-MCO Provider if one of the following exceptions is demonstrated:

a) the drug is not being prescribed for the treatment of substance abuse/dependency/addiction or mental illness or to treat the side effects of psychopharmacological agents. Those drugs are to be prescribed by the PHSS PCP or specialists in the Member's physical care health network;

b) the prescribed drug does not conform to standard rules of the pharmacy services plan; e.g., use of generic or cost effective alternative(s), purchases from certain pharmacies, and quantity limited to a 30 day supply;

c) the drug is prescribed by a behavioral health Provider identified as not having a signed Provider Agreements with the BH-MCO; or

d) the prescription has been identified as an instance of fraud, abuse, gross overuse, or is contraindicated because of potential interaction with other medications.

iii) for HC Zones that have mandatory PH-MCOs, BH-MCO representation on each HC PH-MCO's panel of physicians and other clinicians selecting the PH-MCO formulary. The PH-MCOs formularies or the reimbursable methods of administering drugs (e.g., use of injectibles) must be reviewed and approved by both OMAP and OMHSAS prior to program implementation and for any subsequent change;

iv) procedures for monitoring behavioral health pharmacy services provided by the PHSS;

v) procedures for notifying each other of all prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records;

vi) procedures for the timely resolution of any disputes which arise from the payment for or use of pharmaceuticals (e.g., use of anti-convulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when resolution between the PHSS and BH-MCO does not occur;

vii) procedures for sharing independently developed Quality Management/Utilization Management information related to pharmacy services, as applicable;
viii) policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations [Section 4401(g) of OBRA 1990, Section 4.26, guidelines 1927(g), 42 CFR 456]; and

ix) procedures for the BH-MCO to collaborate with the PHSS in identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs. Areas for particular attention include potential and actual adverse drug reactions; therapeutic appropriateness; over and under drug use; appropriate use of generic products; therapeutic duplication; drug/disease contraindications; drug to drug interactions; incorrect drug dosage or duration of treatment; drug allergy reactions; and clinical abuse/misuse.

x) The BH-MCO is required to provide the PHSS, upon its request, with a listing of the physicians in its initial Provider network and, on a quarterly basis, changes including terminations and additions.

2) The BH-MCO must ensure through its Provider Agreements that its Providers interact and coordinate services with the PHSS and their PCPs.

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

a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.

b. Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.

c. Provide health records to each other, as requested.

d. Comply with the agreement between the BH-MCO and the PHSS to assure coordination between behavioral and physical health care including resolution of any clinical dispute.

e. Be available to each other for consultation.
3) The Primary Contractor or its BH-MCO must establish procedures, which include referrals and interagency service planning, to coordinate In-Plan Service delivery with services delivered outside the scope of services covered by the BH-MCO:

a. Supplemental Services

In addition to the In-Plan mental health, drug and alcohol and behavioral services listed in II-4 A.1), supplemental mental health and drug and alcohol services may be made available to Members when the Primary Contractor determines the service to be clinically appropriate. Supplemental Services are MA eligible services which are not part of the capitated, In-Plan benefit package. The Primary Contractor or its BH-MCO may, however, choose to purchase such services, in lieu of or in addition to an In-Plan Service. Further information regarding Supplemental Services is contained in Appendix Z.

b. Medical Care

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

i) privately-operated ICF/MR, and intermediate care facilities for persons with other related conditions);
ii) mental health residential treatment facilities;
iii) acute and extended acute psychiatric inpatient facilities;
iv) non-hospital residential detoxification, rehabilitation and halfway house services for drug/alcohol abuse or dependence; and
v) juvenile detention facilities for up to 35 days.
All emergency room services in general hospitals are the responsibility of the Member's PHSS, regardless of the diagnosis or services provided except for evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act. Such evaluation is the responsibility of the BH-MCO pursuant to the terms of the written agreement described in II-4.B.1a. Responsibility for ensuring admissions will be based on the Member's Primary Diagnosis.

All emergency and non-emergency medically necessary ambulance transportation for both physical and Behavioral Health Services is the responsibility of the Member’s PHSS even when the diagnosis is provided by the BH-MCO.

c. Public Psychiatric Hospitalization

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

d. Emergency Services: Coverage and Payment

The Primary Contractor or its BH-MCO may not deny payment for Emergency Services obtained when a representative of the entity instructs the Member to seek Emergency Services.

The Primary Contractor or its BH-MCO may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

The Primary Contractor or its BH-MCO may not refuse to cover Emergency Services based on the emergency room Provider, hospital or fiscal agent not notifying the Member’s BH-MCO of the Members screening and treatment within ten (10) calendar days of presentation for Emergency Services.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Responsibility for inpatient admission will be based upon the Member’s Primary Diagnosis.
The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and the determination is binding on the Primary Contractor and its BH-MCO.

4) The Primary Contractor or its BH-MCO must enter into a written agreement with the CCYA to include, at a minimum:

a. Procedures for referral, authorization and coordination of care, including overall requirements for children and adolescents in substitute care and specific requirements for referral, review of Medical Necessity prior to admission to and coordination of care following discharge from accredited and non-accredited RTF services, and D&A non-hospital residential rehabilitation and detox programs.

b. Liaison relationships for individual cases and administration.

c. Release of records and BH-MCO representation in court.

d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.

e. Procedures to communicate denials of service by the BH-MCO.

f. Provision of BH-MCO Provider directories, including electronic transmission where children and youth agency capacities exist.

5) For children and adolescents who are served by multiple child serving systems, the Primary Contractor or its BH-MCO must:

a. Have well publicized written policies and procedures explaining the Primary Contractor or its BH-MCO is available to attend or convene Interagency Team meetings, at the request of or with the consent of the parent or custodian.

b. Treat as a formal request for service a prescriber's request for services pursuant to an Interagency Team recommendation, with the deadlines and Complaint, Grievance and DPW Fair Hearing rights outlined in Appendix H.

c. At the parent/custodian's or agency's request, serve on an Interagency Team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.

d. Coordinate specialized treatment plans for children and adolescents with special health needs, including early intervention.
6) The Primary Contractor or its BH-MCO is required to coordinate service planning and delivery with human services agencies. The Primary Contractor or its BH-MCO is required to have a letter of agreement with:

a. Area Agency on Aging.
b. County Juvenile Probation Office (including the same components as the agreement with the CCYA in II-4.B.4)).
c. County Drug and Alcohol Agency, including:
   i) A description of the role and responsibilities of the SCA.
   ii) Procedures for coordination with the SCA for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.
d. County offices of MH and MR, including coordination with the Health Care Quality Unit (HCQU).
e. Each school district in the county.
f. County MH/MR Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.
g. Early intervention including:
   (i) Infant-toddler early intervention (0-3 yrs) administered by the County MR office.
   (ii) Pre-school intervention (3-5 years) administered by the local MAWA (mutually agreed upon written arrangement). The MAWA is most typically the Intermediate Unit.

7) The Primary Contractor or its BH-MCO must have in place written agreements with the other Primary Contractors or their BH-MCOs in the HC Zone to ensure continuity of care for Members who relocate from one HC county to another. The Primary Contractor or its BH-MCO must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC Zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.
C. Member Services/Member Rights

1) The Primary Contractor and its BH-MCO must comply with any applicable federal and state laws that pertain to Members’ rights and ensure that their staff takes those rights into account when furnishing services to Members.

2) Member Orientation

a. In consultation with the Department, the Primary Contractor and its BH-MCO must develop and distribute culturally/disability sensitive materials to Members regarding program features, policies, and procedures.

b. The Primary Contractor and its BH-MCO must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.

c. The Primary Contractor or its BH-MCO must provide to Members, within five days of enrollment, the names, locations, telephone numbers of, and non-English languages spoken by, current network Providers in the Member’s service area, including identification of Providers that are not accepting new patients. In addition, the Primary Contractor and MCO its BH-MCO must provide a list of current In-Plan behavioral health network Providers to the Member upon the Member’s request. The Primary Contractor and its BH-MCO must make a good faith effort to give written notice of terminated contracts within 15 days after receipt or issuance of a termination notice, to each Member who receives primary care from or was seen on a regular basis by the terminated Provider.

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

e. The Primary Contractor and its BH-MCO must publish and distribute a Member handbook, upon approval by the Department and input from counties served, to all Members within 5 days of enrollment and make it available to other interested parties, upon request. In addition, the Primary Contractor’s BH-MCO must notify all Members of their right to request and obtain information related to the Provider network, benefits, Member rights and protections, and Complaint, Grievance, and DPW Fair Hearing procedures at least once a year. The handbook must be printed at no higher than a fourth grade reading level, delineating a Member's rights and responsibilities, as well as covering the following information:

i) the amount, duration and scope of In-Plan Services and an explanation of any service limitations or exclusions;
ii) a specific statement that provides: “this managed care plan may not cover all your health care expenses. Read your contract (handbook) carefully to determine which health care services are covered;”

iii) how to contact Member Services and a description of its function;

iv) no co-pay or cost sharing obligation by the Member;

v) how to choose Providers within a level of care;

vi) how to obtain emergency transportation and non-emergency medically necessary transportation;

vii) the extent to which and how Members may obtain benefits from Out-of-Network Providers;

viii) the counseling or referral services the Primary Contractor and its BH-MCO does not cover because of moral or religious objections. The Primary Contractor and its BH-MCO must inform Members that the Department will furnish information on how and where to obtain the service;

ix) how to obtain services when a Member moves or visits out-of-county/out-of-state;

x) explanation of the procedures for accessing Behavioral Health Services, including self-referred and Prior Authorized Services;

xi) confidentiality protections, including access to clinical records by oversight agencies and through the Quality Management/Utilization Management program;

xii) information concerning methods for coordinating services for Members;

xiii) how to obtain Medical Assistance Transportation Program (MATP) services;

xiv) phone numbers of the clinical sentinel and BH advocacy agencies;

xv) phone number of the Department’s Fraud and Abuse hotline;

xvi) information on “Advance Directives” (durable power of attorney and living wills), including the following:

a) written policies and procedures per State mandates and requirements;

b) the description of State law;

c) the process for notifying the Member of any changes in State law. The information must reflect changes in state law as soon as possible but no later than ninety (90) days after the effective date of the State law change;

d) any limitation the Primary Contractor and its BH-MCO has regarding implementation of advanced directives as a matter of conscience;
e) the process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the plan and the State survey certification agency.

xvii) information to adult Members regarding Member rights.

xviii) explanation of the operation of the BH-MCO.

xix) explanation of how Members are assisted in making appointments and obtaining services including the explanation of procedures for accessing self-referred and Prior Authorized Services.

xx) explanation of how Members are assisted to obtain transportation through MATP.

xxi) explanation of how Member Complaints and Grievances are handled.

xxii) explanation of rights, which must include the following:

a) each Member will be treated with respect and with due consideration for his or her dignity and privacy;

b) each Member will receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand;

c) each Member will participate in decisions regarding his or her health care, including the right to refuse treatment unless the individual meets criteria for involuntary treatment under the MH/MR Act of 1966;

de) each Member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of seclusion and restraint;

d) each Member may request and receive a copy of his or her medical records and request that they be amended or corrected in accordance with the Federal Privacy Law;

e) each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Primary Contractor, its BH-MCO, Providers or any state agency treats the Member;

f) each Member has the right to request a second opinion from a qualified health care professional within the Provider network. The Primary Contractor’s BH-MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.
xxiii) restrictions on the Member’s freedom of choice among Providers.

(f) In addition to including the following information in the Member handbook, the Primary Contractor and its BH-MCO must provide each Member written notice of any Department-approved change in the following information at least 30 days before the intended date of the change:

i) Complaint, Grievance, and DPW Fair Hearing procedures and timeframes (as provided in Appendix H) that must include the following:

a) For DPW Fair Hearings.
   i. the right to hearing.
   ii. the method for obtaining a hearing.
   iii. the rules that govern representation at the hearing.

b) The right to file Complaints and Grievances.

c) The requirements and timeframes for filing a Complaint or Grievance.

d) The availability of assistance in the filing process.

e) The toll-free numbers that the Member can use to file a Complaint or Grievance by phone.

f) The fact that, when requested by the Member, benefits will continue if the Member files a Complaint (one of the five types of Complaints that allow for continuation of benefits, as specified in Appendix H), Grievance or request for DPW Fair Hearing within the timeframes specified for filing.

g) Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

ii) Instructions for obtaining care in an emergency, including:

a) locations of any emergency settings and other location at which Providers and hospitals furnish Emergency Services;

b) the use of the 911-telephone system or its local equivalent;

c) what constitutes an Emergency Medical Condition, Emergency Services;

d) the fact that Prior Authorization is not required for Emergency Services;

e) the fact that the Member has a right to use any hospital or other setting for Emergency Services.
3) The Primary Contractor and its BH-MCO must develop and implement programs for public education and prevention including behavioral health education materials and activities.

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

D. Member Disenrollment

1) General Authority

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

2) Reasons for Disenrollment

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

a. Member's loss of Medical Assistance eligibility.

b. Placement of the Member in a nursing facility for more than 30 consecutive days.

c. Placement of the Member in any state facility, including a state psychiatric hospital.

d. Placement of the Member in a Juvenile Detention Center for more than 35 consecutive days.

e. Change in permanent residence of the Member which places the Member outside the BH-MCO's service area.

f. Change in Member’s status to a recipient group which is exempt from the HC Program.

g. Determination by the Department that the Member is eligible for the Health Insurance Premium Payment Program (HIPP).

h. Member’s enrollment in the Pennsylvania Department of Aging (PDA) Waiver.

i. Member residing in PA Veterans Home, effective January 1, 2009, contingent upon approval from CMS of a State Plan Amendment (Please Note: The Primary Contractor will be notified when this change is approved by CMS).

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

E. Complaint and Grievance System

1) General

The Primary Contractor’s BH-MCO must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress against the BH-MCO. The Primary Contractor or its BH-MCO may not take any adverse action against a Provider for assisting a Member in the understanding of or filing of a Complaint or Grievance under the Member Complaint and Grievance system.

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

2) Member Complaint and Grievance System

The Primary Contractor’s BH-MCO must develop, implement, and maintain a Complaint and Grievance system which provides for settlement of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in Appendix H.

a. The Primary Contractor’s BH-MCO must provide Members and Parents/custodians of children and adolescents (for CISC, both Parents, if whereabouts are known and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DPW Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a Complaint or Grievance.

b. The Primary Contractor and its BH-MCO must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the Primary Contractor or its BH-MCO.

c. Denials of service or coverage must be in writing, notifying the Member or parent/custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a Grievance and/or request a DPW Fair Hearing and the process for doing so.
d. The Primary Contractor’s BH-MCO must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.

e. The Primary Contractor’s BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.

f. The Primary Contractor’s BH-MCO must provide all required Member Complaint and Grievance information to the Enrollment Assistance Program as requested.

g. The Primary Contractor’s BH-MCO's Grievance system may not be a prerequisite to or replacement for the Member's right to request a Fair Hearing (in accordance with 42 CFR 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the Primary Contractor’s BH-MCO. The Primary Contractor and its BH-MCO must cooperate with and adhere to the Department’s procedures and decisions.

h. Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS's Office of Inspector General, and the United States Justice Department.

3) Denial of Services

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

The BH-MCO may not deny or reduce the amount, duration, or scope of a required service solely because of a Member’s diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the Primary Contractor’s BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request. Any time the Primary Contractor’s BH-MCO denies a request for authorization for service, the Primary Contractor’s BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:
4) Provider Complaint System

The Primary Contractor’s BH-MCO must develop, implement and maintain a Provider Complaint system which provides for informal mediation and settlement of Provider Complaints at the lowest administrative level and a formal Complaint process when informal resolution is not possible.

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

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

II-5. REQUIREMENTS

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

A. General

Participation will be limited to Primary Contractors who are either counties or Multi-County Entities. A County Operated BH-MCO established as an arm or branch of county government is not subject to licensure, so long as the county maintains responsibility for all financial risk. A County Operated BH-MCO established as an arm or branch of county government must be certified by the Commonwealth as a Utilization Management entity under Act 68 if it directly performs Utilization Management functions. In the event a Multi-County Entity submits a single proposal, each county must be separately responsible for financial risk. One county may not assume the financial risk of the other county(ies)
covered by the proposal; nor may a remaining county(ies) assume responsibility for the membership of a terminating county.

B. Executive Management

1) The development of the behavioral health managed care program is a broad based process. The Primary Contractor must have documentation of the participation of consumers, persons in recovery and family members, including Parents of children and adolescents, as well as county drug and alcohol, mental health and mental retardation, children and youth, juvenile justice, and Area Agency on Aging programs and school districts in the development of the behavioral health managed care program. Participation must include the involvement of consumers, persons in recovery, and family members in the selection of a BH-MCO Subcontractor if one is used and development of the proposal in response to the Department's document. Consumers, persons in recovery and family members must also be involved in ongoing program oversight.

2) In the event a county or MCE is the Primary Contractor, the county (separate from the BH-MCO) must establish an administrative structure for management and program oversight of the behavioral health managed care program. The management structure must include clearly defined and assigned responsibility for monitoring the BH-MCO's fiscal, program/Quality Management and management information systems. The Primary Contractor oversees and is accountable for any functions and responsibilities it delegates to the BH-MCO or any Subcontractor.

3) Subcontractual Relationships and Delegation

For each Subcontract, the Primary Contractor and its BH-MCO must ensure that:

a. The Subcontractor has been evaluated and determined competent to perform the activities to be delegated.

b. The Subcontractor has been engaged pursuant to a written agreement between the Primary Contractor and/or its BH-MCO and the Subcontractor that specifies the activities and reporting responsibilities delegated to the Subcontractor and provides for revoking delegation or imposing other sanctions if the Subcontractor’s performance is inadequate.

c. Performance monitoring will be conducted on an ongoing basis, and the Subcontractor and will be subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.
d. Deficiencies or areas for improvement will be identified, and corrective action is required.

4) Primary Contractors and their BH-MCOs are required to place all HealthChoices Capitation payments in a separate, restricted account(s).

5) The Primary Contractor is required to contract with C/FST services in the counties served or establish such teams if they do not exist.

6) If the Primary Contractor is a county, the Primary Contractor is required to place Reinvestment Funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DPW. Primary Contractors must have prior approval from DPW to carryover Reinvestment Funds from one Agreement period into a subsequent Agreement period; however, DPW approved reinvestment plan funds must continue to be tracked separately. Counties can maintain Reinvestment Funds, for DPW approved reinvestment plans, up to six (6) months after the time period delineated in their approved reinvestment plan, unless such date is otherwise extended by the Department. This includes reinvestment plans that cover more than one (1) period. After that time, unexpended Reinvestment Funds must be returned to the Department. Any funds remaining in the reinvestment account at the time of Agreement termination must be returned to DPW.

7) The Primary Contractor and or its BH-MCO may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:

a. A Chief Executive Officer with clear authority over the entire operation of the BH-MCO.

b. A Medical Director who is a board certified psychiatrist licensed in the Commonwealth with at least five years combined experience in mental health and substance abuse services. The responsibilities of the Medical Director include:
   i) development of clinical practice standards, policies, procedures, and performance;
   ii) review and resolution of quality of care problems;
   iii) participation in Complaint and Grievance processes related to service denials and clinical practice;
   iv) development, implementation, and review of the internal Quality Management and Utilization Management programs;
   v) oversight of the BH-MCO's referral process for specialty and Supplemental Services;
vi) oversight and management of the BH-MCO's behavioral health rehabilitation and residential services for children and adolescents, in collaboration with the HealthChoices PH-MCO's Medical Directors;

vii) leadership and direction in the BH-MCO's clinical staff recruitment, credentialing, and privileging activities;

viii) leadership and direction in the BH-MCO's Prior Authorization and utilization review processes;

ix) leadership and direction of policies and procedures relating to confidentiality of clinical records; and

x) participation in any meetings called by the Department.

c. A Chief Financial Officer (or governmental equivalent) to oversee the budget and accounting system.

d. Quality Management

e. Utilization Management

f. Management Information Systems

g. Prior Authorization to include:

i) assessment and substantiation of need for psychiatric and behavioral services provided by a mental health professional;

ii) assessment and substantiation of need for drug and alcohol treatment services provided by a Drug and Alcohol Addictions Professional.

h. Member Services to communicate with Members, act as Member advocates, and coordinate Members' use of the Complaint and Grievance processes.

i. Provider Services to coordinate communications between the BH-MCO and its Providers.

8) The Primary Contractor’s BH-MCO must organize and deliver services in accordance with principles established through the Child and Adolescent Service System Program (CASSP), the Community Support Program (CSP); and BDAP's Principles of Effective Treatment and OMHSAS’ Cultural Competency Principles; see Appendices I, J, and CC respectively.

9) The Primary Contractor or its BH-MCO must have written agreements with the county mental health, mental retardation and drug and alcohol authorities assuring availability and access to In-Plan and Supplemental Services. Agreements must include provisions for the integration of crisis intervention services and the admission of any Member to a state mental hospital consistent with the established state mental hospital bed allocation assigned to the county as well as provisions for appropriate, coordinated response and dispute resolution processes related to court orders for behavioral health involuntary treatment services.
C. Administration

1) Administrative duties related to the daily operation of the program and interaction with Providers and Members such as those related to Member services, Provider services, Quality Management and Utilization Management, must be conducted in an administrative office in close geographic proximity to the county in which services are provided.

2) The HealthChoices Program, through the Enrollment Assistance Program, provides Enrollment Specialists to assist Members with enrollment in a PHSS, and to provide Members with information regarding the PH-MCO and BH-MCO programs.

   The EAP is responsible for pre-implementation outreach and education for Members and families to explain the fundamental concepts of managed care and for providing information on benefit packages.

   The Primary Contractor or its BH-MCO must have policies and procedures for coordination with the EAP. The Primary Contractor or its BH-MCO must have informational materials; e.g., pamphlets and brochures, which can be used by the EAP to assist the Member’s access to Behavioral Health Services. Any informational materials developed for this program by the Primary Contractor or its BH-MCO must have the Department's prior, written approval. The Primary Contractor or its BH-MCO will be required to print and provide the EAP with an adequate supply of approved materials on a continual basis.

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

3) Training and Professional Development

   The Primary Contractor or its BH-MCO must provide an ongoing process of training and professional development for BH-MCO Member services, Service Management, Quality Management and Utilization Management staff. Training topics should include but not be limited to: CSP and CASSP principles and BDAP treatment philosophy, Member rights, Complaint and Grievance process, Provider network access, human services, current clinical practice needs of special populations including persons with co-occurring mental health drug & alcohol conditions, persons with mental retardation, children in substitute care and/or in juvenile probation, persons diagnosed with ASD, school intervention services, and Medical Necessity criteria including the ASAM and PCPC.

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4) The BH-MCO must monitor the performance and quality of service of any BH Services Provider to which work is delegated to assure conformance with the terms of the Agreement.

5) The BH-MCO must work in partnership with the designated county/municipal health department, and primary care practitioner as applicable, to ensure that conditions identified in accordance with Chapter 25, Disease Prevention and Control Law (35 P.S. § 521.1 et seq.) are reported (e.g., tuberculosis, hepatitis).

6) Records Retention

a. General

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

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

The Primary Contractor, its BH-MCO and BH Services Providers must, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives, or federal agencies. Access shall be provided either on-site, during regular business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.

The Primary Contractor, its BH-MCO and BH Services Providers shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records, other than medical records, may be kept in an original paper state or preserved on micro media or electronic format.
Medical records shall be maintained in their original form. Financial books, records, documents, and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives up to five years after the date of the last payment under the Agreement, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all work is completed.

b. Operational Data Reports

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

c. Clinical Records

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

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

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to Members. Therefore, the Primary Contractor or its BH-MCO must have written standards for clinical record documentation which reflect legibility, accuracy, completeness, and that chronologically reflect the evaluation, appropriateness of treatment, and Medical Necessity within the plan of care for the Member. A complete list of standards to follow is contained in 55 Pa. Code, Chapter 1101 general MA regulations and the HealthChoices clinical record components document located in the HealthChoices Library.

Clinical records must be legible, signed, dated, preserved, and maintained for a minimum of five years from expiration of the Agreement. Clinical records must be maintained in the original form before conversion to any other form and records in all forms must be readily available for review.
The Department is not required to obtain written approval from a Member before requesting the Member's clinical record from the Primary Contractor or its BH-MCO or any Provider, consistent with state and federal confidentiality requirements.

D. Provider Network/Relations

1) The Primary Contractor and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network must have the following features in place and documented:

a. Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.

b. Represent the cultural and ethnic diversity of Members and their neighborhoods.

c. Clinical expertise and Cultural Competency in responding to Members with special needs.

d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance abuse disorders among older adults (particularly those with co-existing medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS, or persons diagnosed with ASD.

e. Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.

f. Evidence of a cooperative relationship between the BH-MCO and its Provider network, for example, inclusion of Providers by the BH-MCO in the development of clinical protocols and Provider profiling.

g. The numbers of network Providers who are not accepting new Members.

h. The anticipated MA enrollment.

i. The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the BH-MCO.

j. The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.
k. The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

2) The Primary Contractor or its BH-MCO must ensure management of the Provider network through agreements which include the following provisions:

a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.

b. Criteria for Provider's clinical privileges, as applicable.

c. Clinical performance standards and data reporting requirements.

d. Financial performance standards and data reporting requirements.

e. Complaint procedures for Providers.

f. Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.

g. Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., mental retardation, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.

h. Requirements for coordination, credentialing, and continuity of care with PHSS and PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).

i. Procedures for approving demonstration projects for In-Plan Service and treatment alternatives/innovations.


k. Compliance with Act 13 (Older Protective Services Law) 35 P.S. 10225, 101 et seq. background checks for working with older persons.

l. Authorization of In-Plan Services in accordance with DPW approved Medical Necessity criteria and Prior Authorization procedures.

m. Assurance that Providers delivering In-Plan Services to Members via a subcontractual arrangement with a network Provider, meet the same requirements and standards as a network Provider.

n. Procedure to provide access to client records for quality of care and access reviews.

o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of network)
3) The Primary Contractor or its BH-MCO must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The BH-MCO must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

4) The Primary Contractor or its BH-MCO must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis. The Primary Contractor or its BH-MCO must make incident records and reports immediately available to the Department upon request.

5) The Primary Contractor or its BH-MCO must maintain procedures for immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OMAP, Bureau of Program Integrity.

6) The Primary Contractor or its BH-MCO must notify the Department promptly of any changes to the composition of its Provider network that affect the Primary Contractor or its BH-MCO's ability to make available all In-Plan Services or respond to the special needs of a Member or population group in a timely manner.

7) The Primary Contractor (PC)/BH-MCO shall develop a policy and procedure for considering Provider rate setting for review and approval by OMHSAS. The policy shall include the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies. The policy will include a statement that the PC/BH-MCO shall not institute an across the board rate decrease for all Providers or a specific Provider type or group of Providers unless the PC or its BH-MCO has: (i) notified the Department of its intention to impose such an across the board rate decrease at least forty-five (45) days prior to the imposition of such a rate decrease; (ii) provided the Department with the justification for instituting such an across the board rate decrease (iii) discussed the proposed action with all affected Providers, and (iv) provided justification that such action will not adversely affect compliance with HealthChoices access and choice requirements.
8) The Primary Contractor or its BH-MCO must maintain a plan of orientation and ongoing training for network Providers. Training shall include but not be limited to:

CASSP and CSP principles and BDAP treatment philosophy; priority and Special Needs Population issues such as children in substitute care and/or juvenile probation; Prior Authorization of services; continuity of care; payment procedures; Complaint and Grievance rights and procedures; coordination requirements with PHSS and PCPs; coordination requirements with county behavioral health and human services systems; current clinical best practice and community service resources and advocacy organizations.

E. Provider Enrollment - Credentialing/Recredentialing

1) In maintaining the Provider network, the Primary Contractor or its BH-MCO must establish written credentialing and recredentialing policies and procedures. Primary Contractor or its BH-MCOs must adhere to credentialing requirements under the Pennsylvania Department of Health regulations at 28 Pa. Code, Sections 9.761 and 9.762 for all In-Plan Services Provider types as well as for Providers of Supplemental Services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the Primary Contractor or its BH-MCO (who will ensure the service is within the Provider’s scope of practice) and approval from a county who wishes to offer the service. The Primary Contractor or its BH-MCO must submit a program description to OMHSAS for review. Upon approval of the service description, OMHSAS will determine the code that will be used in the HC Program only, and the Provider will report encounter data for this service under their existing Provider type designation. Credentialing policies and procedures must include, but not be limited to, the following criteria:

a. Applicable license or certification as required by Pennsylvania law.

b. Verification of enrollment in good standing with Medicaid (Providers of Supplemental Services must be enrolled in the MA program)

c. Verification of an active MA Provider Agreements.

d. Evidence of malpractice/liability insurance.

e. Disclosure of any past or pending lawsuits/litigations.

f. Board certification or eligibility, as applicable.
2) Except as provided by 42 CFR 438.12(b), the Primary Contractor or its BH-MCO may not discriminate for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Primary Contractor or its BH-MCO declines to include individual or groups or Providers in its network, it must give the affected Providers written notice of the reason for its decision.

3) The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

4) A Primary Contractor or its BH-MCO may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
   a. any information the Member needs in order to decide among all relevant treatment options.
   b. for the risk, benefit and consequences of treatment and non-treatment.
   c. for the Member’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.
   d. for Member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.

5) The Primary Contractor, its BH-MCO or Subcontractors may not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

6) A Primary Contractor or its BH-MCO shall have a process in place, approved by the Department, for consulting with the counties served regarding Providers to be enrolled in the network and those recredentialed.

F. Service Access

1) The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for Urgent situations, and within seven days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the Start Date and frequency of treatment services. Prior Authorization of emergency inpatient and emergency outpatient services is not permitted.
The Primary Contractor or its BH-MCO must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred Member within the access standard.

2) The Primary Contractor and its BH-MCO must maintain a Provider network which is geographically accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the Member travels is at least two (2) Providers for each In-Plan Service:

   a. Within 30 minutes travel time in Urban areas.
   b. Within 60 minutes travel time in Rural areas.

   The access standard for inpatient and residential services is at least two Providers for each In-Plan Service, one of which must be:

   a. Within 30 minutes travel time in Urban areas.
   b. Within 60 minutes travel time in Rural areas.

   The access standard for in plan crisis intervention services (telephone and mobile) is a minimum of one Provider. The access standard for Drug and Alcohol Halfway House services is two Providers, regardless of gender segregation. That is, the BH-MCO does not need to require two Providers each for halfway house services for both males and females.

   Network Providers are not required to be located within the county covered by the Agreement. Adherence to the travel time requirements may be facilitated by the Primary Contractor or its BH-MCO's inclusion of out-of-county BH Services Providers in its network.

   The Primary Contractor or its BH-MCO must obtain DPW approval for policies and procedures to cover situations in which the Primary Contractor or its BH-MCO determines that a Member is in need of a specialized In-Plan Service and a Provider is not available within the travel timeframes. The policy and procedures shall ensure the appropriate delivery of services and the availability of local supports for the Member.

3) The Primary Contractor’s BH-MCO must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process in accordance with Appendix T for admission, continued stay and discharge for all In-Plan Services. The Primary Contractor or its BH-MCO's service authorization system must include procedures for informing Providers and Members of authorization decisions.
4) The Primary Contractor or its BH-MCO must have written policies and procedures which comply with MA Bulletin 99-96-01 and Appendix V, to authorize care and transition Members to network Providers for Members who are in care at the time of the Agreement implementation. (Note, Bulletin 99-96-01 is specific to continuity of Prior Authorized Services for Members under age 21.) Policies and procedures must specifically address priority and Special Needs Populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers must also be included. Where disruption of services would have a significant negative impact on the Member, the Primary Contractor and its BH-MCO must have provisions for the authorization and payment of services delivered by Out-of-Network Providers. A transition monitoring plan must be developed to ensure that procedures and protocols governing transition into service are being followed and that transition problems are identified and corrected. The transition plan should also address the Primary Contractor or its BH-MCO staff recruitment and training prior to start-up and supervisory support during initial implementation. Planning must also address network Provider credentialing, contracting and training; the Primary Contractor or its BH-MCO telephone capacity related to both Member services and Service Management functions; and MIS backup.

5) The Primary Contractor or its BH-MCO must have procedures for accessing Out-of-Network, but In-Plan Services in emergency or unique situations including services for children and adolescents in substitute care.

6) The Primary Contractor and its BH-MCO must have procedures to assure continuity of care for Members affected by either Provider termination or loss of the Member’s MA eligibility when Medical Necessity continues at the same or other level of care.

7) If 5% or more of the MA recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the Primary Contractor or its BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, written notifications, etc. Interpreter services must be available, as practical and necessary, by telephone and/or in person to ensure Members are able to communicate with the Primary Contractor or its BH-MCO and Providers, and receive covered benefits in a timely manner. The Primary Contractor must have policies and procedures for ensuring language assistance services for people who have limited proficiency in English.
In addition, the Primary Contractor and its BH-MCO must comply with the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq.) concerning the availability of appropriate alternative methods of communication for Members who are visually impaired, deaf or hard of hearing. Such appropriate alternative methods include, but are not limited to, Braille, audio tapes and/or computer diskettes. The Primary Contractor or its BH-MCO must provide Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication Relay Services for communicating with Members who are deaf or hard of hearing, and comply with the ADA concerning access for Members with physical disabilities.

8) The Primary Contractor or its BH-MCO is expected to refer any Member in need of any routine and specialized medical and/or social service not provided by the BH-MCO to an appropriate agency/organization.

9) The Primary Contractor or its BH-MCO and its Provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa. C.S. Section 6311.

10) The Primary Contractor or its BH-MCO must assure that Members are provided reasonable access to Behavioral Health Services provided by Federally Qualified Health Clinics (FQHC), wherever FQHC Behavioral Health Services are available, within travel of 30 minutes (Urban) and 60 minutes (Rural).

11) In all agreements with health care professionals, the Primary Contractor or its BH-MCOs must comply with the requirements specified in 42 CFR 438.214, which includes selection and retention of Providers, credentialing and recredentialing requirement and nondiscrimination.

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

1) General

The Primary Contractor or its BH-MCO must adhere to Department of Health Regulation 28 Pa. Code Chapter 9, Subchapter G. The Primary Contractor or its BH-MCO must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

a. Conform to state Medicaid plan QM requirements.

b. Assure a UM/QM committee meets on a regular basis.
c. Provide for regular UM/QM reporting to the Primary Contractor or its BH-MCO management and its Provider network (including profiling of Provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the PHSS.

d. Provide opportunity for consumer (including representation for consumers in Special Needs Populations), persons in recovery and family (including Parents/custodians of children and adolescents) participation in program monitoring.

2) Utilization Management (UM)

The Primary Contractor or its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval (in accordance with Appendix AA), determination of Medical Necessity, Concurrent Review, Denial of Services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of its UM function, the Primary Contractor or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of Behavioral Health Services, procedures, and use of facilities.

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

3) Quality Management

a. The Primary Contractor or its BH-MCO agrees to implement a Quality Management program that includes a Continuous Quality Improvement (CQI) process. The Primary Contractor or its BH-MCO agrees to fully comply with the Department’s Quality Management and Utilization Management standards. The Primary Contractor or its BH-MCO must provide that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the
individual or entity to deny, limit, or discontinue medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects to be required by the Department in their contracts with the Primary Contractor, its BH-MCO and its Subcontractors must agree to cooperate fully in implementing these performance measures and projects.

b. Performance Improvement Projects

The Primary Contractor or its BH-MCO is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

The performance improvement projects must involve the following:

i) Measurement of performance using objective quality indicators.
ii) Implementation of system interventions to achieve improvement in quality.
iii) Evaluation and initiation of activities for increasing or sustaining improvement.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

The Primary Contractor is required to report the status and results of each project to the Department, as requested.

The BH-MCO must have a written Quality Management plan that includes quality assessment and performance improvement processes designed to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. The continuous quality improvement process places emphasis but need not be limited to, high volume and high risk services and treatment and behavioral health rehabilitation services for children and adolescents.

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

4) Confidentiality

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

5) Member Satisfaction

The Primary Contractor, its BH-MCO or Subcontractor must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (C/FST) (in accordance with Appendix L).

The Primary Contractor or its BH-MCO shall contract with existing C/FST, or establish such teams if they do not exist, to conduct satisfaction surveys for Members. The Subcontract shall ensure technical support of the C/FST in report writing, conducting interviews and include funds for travel and staff development. The Department will approve the C/FST Subcontracts established.

An annual report must be submitted to the Department on the activities and findings of the C/FST and Member satisfaction survey. Members and their families, including Parents of children and adolescents who are seriously emotionally disturbed and/or who abuse substances, or have been diagnosed with ASD, are to participate on the consumer/family satisfaction teams and in the design and implementation of the survey process. Such participation is to include: serving on C/FST, the review of C/FST and annual survey findings, and the determination of quality improvements to be undertaken based on the findings. The Primary Contractor and its BH-MCO should also have mechanisms which ensure that Member comments concerning Provider performance can be tracked in aggregate and be used as a component of Provider profiling. In addition, the Primary Contractor and its BH-MCO must cooperate in Member satisfaction assessments which may be performed by the Department, independent of the Primary Contractor’s or its BH-MCO’s internal process.
6) Provider Satisfaction

The Primary Contractor, either directly or via its BH-MCO or Subcontractor, must have systems and procedures to assess Provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual Provider satisfaction survey. Areas of the survey must include claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management.

7) Department Review

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

8) Performance-Based Contracting

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

9) External Independent Assessment

On at least an annual basis, the Primary Contractor or its BH-MCO must provide necessary documentation in order to comply with independent external quality review organization (EQRO) activities. The review shall include:

a. Validation of the Primary Contractor’s quality improvement projects.
b. Validation of the Primary Contractor’s performance measures.

The Primary Contractor or its BH-MCO must provide, as necessary, a review of its compliance with state structural and operational standards. Information included in the EQRO must be derived from an assessment of compliance with standards that occurred within the last three years.

10) Pay for Performance

The Department implemented a Pay for Performance program which provides for incentive payments in accordance with Appendix E.
II-6.  PROGRAM OUTCOMES AND DELIVERABLES

A. Outcome Reporting

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the Primary Contractor and its BH-MCO must comply with the Department's program performance reporting requirements as delineated in Appendix K. The Primary Contractor or its BH-MCO must establish all coordination agreements and procedures necessary to collect the required data elements from the Providers, Members, etc.

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

The Primary Contractor or its BH-MCO must have a plan in place to review the BDAP CIS data for accuracy and completeness and a plan to work with their Providers to that end.

B. Deliverables

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

1) Member Services  Marketing materials; Member handbooks; educational materials; Complaint and Grievance policies and procedures; Prior Authorization and access policies and procedures; listing of Providers.

2) Administration  Letters of agreement; Provider contracts/Subcontracts; Provider Complaint system procedures; Provider network; staff development plan; Provider directory; Provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral form; coordination agreements; Complaint and Grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and regulations.
3) Quality Management /Utilization Management

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

4) Data

Descriptions of management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; Complaint and Grievance reports; performance outcome management reports, including the consumer registry and quarterly status; transition monitoring and monitoring reports.

5) Behavioral Health Rehabilitation Services for Children and Adolescents

Procedures for informing Members and Providers about services available concerning BHRS; procedures for evaluating Provider compliance with BHRS requirements; procedures for ensuring timely provision of services on an emergency or Urgent basis.

6) Other

Organization chart listing key staff/functions; management information system; management and financial data system; identification and location of service sites; plan for coordination with county mental health and drug and alcohol authorities, as applicable; coordination agreement including procedures for clinical dispute resolution between the PH-MCO and BH-MCO; DUR policies and procedures; incident reports and trend analyses.

II-7. Financial and Reporting Requirements

A. Financial Standards

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

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

2) Risk Protection for High Cost Cases

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

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

The Primary Contractor must submit its plan for risk protection for high cost cases 60 days prior to the beginning of each Agreement period. The Department will determine the acceptability of the reinsurance or alternate risk protection arrangement.

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

Each Primary Contractor must submit its plan 60 days prior to the beginning of each Agreement period to provide for payment to Providers by a secondarily liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The secondarily liable party must insure payment to Providers for all services performed by the BH-MCO’s Providers through the last day for which DPW paid a Capitation premium to the Primary Contractor. The insolvency arrangement must be at a minimum, the equivalent of two months’ worth of paid claims, when determinable, or two months of expected Capitation revenue, in the absence of claims history. The requirement may be met by submitting one or more of the following arrangements:

a. insolvency insurance;

b. an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DPW, or the county or Multi-County Entity, as applicable, to be determined on a case-by-case basis, which is in place for the entire term of the 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 Primary 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.

The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency. DPW must approve all such arrangements prior to the signing of the Agreement. Such approval will include approval of the financial strength of the secondarily liable parties and approval of all legal forms for secondary liability.

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

The following section applies only if the Primary Contractor is a County or Multi-County Entity operated BH-MCO:

a. The Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standard is to assure payment of the Primary Contractor’s BH-MCO’s obligations to Providers and to assure performance by the BH-MCO of its obligations under the Agreement.

Each Primary Contractor must maintain minimum equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of MCO assessment obligations paid as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DPW to the Primary Contractor. During the first year after implementation, the equity may be phased in over the first four quarters of the Agreement. The phase-in requirement is 2% at the end of the first quarter; 3% at the end of the second quarter; 4% at the end of the third quarter and 5% at the end of the fourth quarter.

No later than forty-five days prior to the effective date of this Agreement, the Primary Contractor must provide documentation that the equity requirement is being met, or will be met, by the effective date of the Agreement. The Primary Contractor must provide DPW with a Statement of Revenues and Expenses, balance sheet, and a Statement of Cash Flows, not later than 45 days after the end of each month (See Appendix P, Reports #13, 14, and 15). Statements must be consistent with Generally Accepted Accounting Principles (GAAP). These financial statements must include only information applicable to this Agreement. Each quarter, the balance sheet that provides information as of the last day of a calendar quarter must be accompanied by a certification, by an independent actuary, of the liabilities shown on the balance sheet (See Appendix P, Report #13).

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

The Primary Contractor is required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements under this Agreement.

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

- discuss fiscal situation with the Primary Contractor's management;
- require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
- suspend enrollment of some or all Members into the Primary Contractor’s BH-MCO;
- terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

b. The Primary Contractor shall account for its HealthChoices transactions in an Enterprise Fund.

c. Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et seq.) to pay for HealthChoices Program costs.
5) Equity and Other Requirements

The following requirements apply if the Primary Contractor is a county or a Multi-County Entity and the Primary Contractor contracts with a Private Sector BH-MCO and one of the following conditions applies:

- the cost of the BH-MCO contract is at least 80% of the revenue the county receives from DPW under this Agreement; or

- the contract between the Primary Contractor and the BH-MCO provides that the BH-MCO contractor is substantially at risk to provide services without financial recourse to the county.

a. The requirements of Sections 2), 3), and 4)a. above also apply to the Private Sector BH-MCO contractor if the contract between the Primary Contractor and the Private Sector BH-MCO requires that the Private Sector BH-MCO meet and maintain the risk protection, equity and insolvency arrangement requirements stated in Sections 2), 3), and 4)a.

b. The Primary Contractor shall account for its HealthChoices transactions in a Special Revenue Fund.

c. Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et seq.) to pay for HealthChoices Program costs.

6) Equity and Other Requirements

The following requirements apply if the Primary Contractor is a Private Sector BH-MCO:

a) The requirements of Sections 2) and 3)

b) Equity Requirements – Private Sector BH-MCO

In addition to the Primary Contractor's responsibility to meet requirements of the Insurance Department, the Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standards is to assure payment of the Primary Contractor's obligations to Providers and to assure performance by the Primary Contractor of its obligations under the Agreement.
Each Primary Contractor must maintain minimum SAP-based equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of the MCO Assessment obligations paid as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DPW to the Primary Contractor.

The Primary Contractor's equity as of the last day of the most recent calendar quarter will be determined in accordance with SAP-based equity, as reported to the Insurance Department, and compared to the minimum equity requirement amounts in order to determine compliance with this standard.

The Primary Contractor will be required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If equity is not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements of its Agreement.

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

· Discuss fiscal situation with Primary Contractor management;
· Require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
· Suspend enrollment of some or all recipients into the Primary Contractor’s HC-BH Program;
· Terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

The Primary Contractor must maintain revenues paid by the Department under the Agreement in a contract-specific bank account or accounts. These accounts will not contain funds unrelated to the Agreement. The Primary Contractor may prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.
8) The Primary Contractor must maintain separate fiscal accountability for Medicaid funding under the Waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The Primary Contractor must maintain procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county, if the Primary Contractor has an Agreement in more than one HealthChoices county.

9) DPW's obligation to make payments is limited to the Capitation payments provided by the Agreement. If DPW is obligated as a result of litigation to pay a Provider for a service rendered under the Agreement, the Primary Contractor will have an obligation to DPW in the same amount. DPW may offset an obligation it has to the Primary Contractor by this amount, or DPW may demand payment from the Primary Contractor.

10) Limitation of Liability

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

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

11) Behavioral Health Service Cost Accruals

The Primary Contractor must have actuarial services available to provide rate and other support services needed under the Agreement. The Primary Contractor must provide DPW with an actuarial certification of liabilities quarterly, if a county-operated BH-MCO, and at least annually, if a licensed, risk-bearing entity. As part of its accounting and budgeting function, the Primary Contractor or its BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Primary Contractor or its BH-MCO must reserve funds by major categories of service (e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the Primary Contractor or its BH-MCO should conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary.
12) Financial Performance

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

13) Reporting Penalty

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

B. Acceptance of Department Capitation Payments

The Primary Contractor is capitated for all In-Plan Services. The obligation of the Department to make payments is limited to Capitation payments. The Department shall make Capitation payments to the Primary Contractor on a monthly basis in the following manner:

On the first day of each month, the Department will identify Members, and for each Member whose enrollment is effective on the first of the month, as indicated on CIS, the Department shall make a prepaid, PMPM payment as payment in full for any and all services provided to the Member that constitutes covered services. Payment will be released no later than the 15th day of the month; however, the Department, at its sole discretion, reserves the right to delay until July, all payments that would otherwise occur in June. For Members whose enrollment is effective at any time after the first day of the month, Capitation will be prorated and paid at a later date.
· Appendix V, the HealthChoices Behavioral Health Recipient Coverage Document, provides for adjustments to the Department's obligation to make Capitation payments. Appendix V is subject to revision by the Department in its sole discretion and without the need to amend the Agreement.

· The Capitation payment will be equal to the amount awarded the Primary Contractor through the rating setting process. Monthly Capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

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

   The Department will recover Capitation payments made for the Members who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Members for up to eighteen (18) months after the service month for which payment was made. (See Appendix V, HealthChoices BH Recipient Coverage Document.)

   The Primary Contractor must agree to accept Capitation payments in this manner and must have written policies and procedures for receiving, reconciling and processing Capitation payments.
C. Physician Incentive Arrangements

The Primary Contractor may operate a physician incentive plan only in accordance with Federal requirements for physician incentive plans.

1) If the Primary Contractor or its BH-MCO is an HMO, the following requirements apply:

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

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

2) If the Primary Contractor is a Prepaid Inpatient Health Plan (PIHP) or enters into a contract with a PIHP, the following requirements must be met:

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

1) Payments to Providers

The Department believes that one of the advantages of a behavioral health managed care system is that it permits Primary Contractors and their BH-MCOs to enter into creative payment arrangements intended to encourage and reward effective Utilization Management and quality of care. The Department therefore intends to give Primary Contractors and BH-MCOs as much freedom as possible to negotiate mutually acceptable payment rates. However, regardless of the specific arrangements made with Providers, the Primary Contractor and BH-MCOs must agree to make timely payments to both contracted and non-contracted Providers, subject to the conditions described below. The Primary Contractor and its BH-MCO must also agree to abide by special reimbursement provisions for FQHCs described below.

The Primary Contractor agrees to negotiate and pay rates to FQHCs and Rural Health Clinics (RHCs) comparable to other Providers who provide comparable services in the Primary Contractor’s Provider network. The Primary Contractor cannot pay annual cost settlement or prospective payment. The BH-MCO may require that an FQHC comply with Case Management procedures that apply to other entities that provide similar benefits or services.

The Primary Contractor and its BH-MCO shall not be obligated to pay Providers of authorized Behavioral Health Services unless bills for such services are submitted within one hundred and eighty (180) days from the date of service.

The Primary Contractor and its BH-MCO shall follow state law on invoicing requirements on uniform claims, including the CMS 1500 and UB92, and HIPAA regulations for electronic billing via the 837 I and 837 P.

2) The Primary Contractor and its BH-MCO shall adjudicate 90% of all Clean Claims within 30 days, 100% of Clean Claims within 45 days, and 100% of all claims within 90 days. The Primary Contractor shall provide the Department with a monthly report that supplies summary information on claims processed. This reporting requirement applies to claims processed by the Primary Contractor, its BH-MCO, or a Subcontractor, as well as capitation payments to Providers or Subcontractors of Behavioral Health Services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8), and are also available in the HealthChoices Library.
E. Retroactive Eligibility Period

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

F. Financial Responsibility for Dual Eligibles

The Primary Contractor and its BH-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the contracted BH-MCO rate for the service for network Providers. The Primary Contractor, its BH-MCO and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. If the service is a covered Medicare service, the Primary Contractor is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the BH-MCOs Provider Network and whether or not the Medicare Provider has complied with the authorization requirements of the Contractor. Since Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating Providers, Medicare Providers seeking payment must be enrolled in Medicaid.

If no contracted BH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the Primary Contractor must pay deductibles and coinsurance up to the applicable Medical Assistance fee schedule amount for the service.

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

In the event that Medicare does not cover a service, the Primary Contractor’s BH-MCO may require Prior Authorization as a condition of payment for the service.

The Primary Contractor must ensure that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice, regardless of whether that Provider is enrolled in the BH-MCO network. BH-MCOs may establish policies and procedures for their networks that maximize opportunities for consumers to have a choice of Medicare Providers.
G. Risk and Contingency Funds (Does not apply to a Private Sector BH-MCO as the Primary Contractor)

1) The Primary Contractor shall submit a written request to the Department prior to designating funds as Risk and Contingency. The request must include the proposed purpose of moving funds into Risk and Contingency instead of reinvesting these funds.

2) The approved amount must be placed in the Risk and Contingency account within thirty (30) days of receiving a written approval letter from OMHSAS.

3) With prior written approval from the Department, the Primary Contractor may use Risk and Contingency Funds for the following purposes:
   
a. To provide In-Plan Services and administrative functions required by this document, due to fluctuations in enrollment, revenue and utilization which have caused costs to exceed available Capitation payments;

b. To make payment to its BH-MCO or Subcontractors due to any delay(s) of thirty (30) days or more of receipt of a monthly Capitation payment from the Department;

c. To meet the Primary Contractor’s insolvency arrangement plan under Part II-7 A. of this document. Those Risk and Contingency Funds held for insolvency protection purposes will be restricted and only available in the event of a bankruptcy or insolvency; or

d. To meet the Primary Contractor’s reinvestment plan.

4) Risk and Contingency (R&C) Funds shall at no time exceed the equivalent of thirty (30) days worth of paid claims, as determined by the Department, unless the Primary Contractor (PC) is holding funds in the R&C account in order to meet the Department’s insolvency arrangement requirements in Part II-7 A. as follows:

a) If the R&C Funds are being used to fully meet the Department’s insolvency arrangement requirement (equal to sixty (60) days worth of paid claims), the PC may maintain up to and including seventy-five (75) days worth of paid claims, as determined by the Department.
b) If the R&C Funds are being used to partially meet the Department’s insolvency arrangement requirement (less than sixty (60) days worth of paid claims), the PC may maintain up to and including sixty (60) days worth of paid claims, as determined by the Department.

c) If the R&C Fund is being used to fully or partially meet the Department’s insolvency protection arrangement requirements, the amount being held in the R&C Fund for the insolvency protection arrangement will be included in the calculation of sixty (60) or seventy-five (75) days worth of paid claims. The R&C Fund would then need to be funded, at a minimum, at the amount agreed upon by the Department, at all times.

d) In the event a PC is meeting the insolvency arrangement requirement via R&C Funds, and changes the method in which the insolvency arrangement requirement is met, the days worth of paid claims permitted to be maintained in the R&C Funds would change accordingly.

Funds designated in a reinvestment plan submitted to the Department will not be included in the calculation of the thirty (30), sixty (60) or seventy-five (75) days’ worth of paid claims, as applicable. If the R&C Funds exceed the equivalent of thirty (30), sixty (60) or seventy-five (75) days worth of paid claims, as applicable, at the end of any Agreement period, the PC shall return the excess portion to the Department within fifteen (15) days of written notification from the Department.

5) The Risk and Contingency Fund shall be held in a bank account that is separate from any other HealthChoices bank accounts. Copies of the bank statements must be mailed monthly to the Department.

6) The Risk and Contingency Fund shall be reported as a separate line item on the monthly financial report and audited Balance Sheet submitted for the annual Agreement audit, including a statement of cash flow.

7) Within fourteen (14) months from the termination of the Agreement, any Risk and Contingency Funds remaining in the Primary Contractor’s HealthChoices Special Revenue or Enterprise Fund for the HealthChoices Behavioral Health Program shall be returned to the Department.

In the event that the Department enters into another agreement with the Primary Contractor for the provision of HealthChoices Behavioral Health Services subsequent to a current Agreement’s termination, the Department reserves the right, in its sole discretion, to allow the Primary Contractor to retain all, or a portion thereof, of Risk and Contingency Funds otherwise owed to the Department.
9) The Department reserves the right to revise the Risk and Contingency Fund requirements at its discretion. Any revisions will be implemented in compliance with timelines defined in the Agreement.

H. Return of Funds

(1) and 2) does not apply to a Private Sector BH-MCO as the Primary Contractor

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

2) In the event that the Agreement with the Department ends and is not renewed, all funds, except for those in DPW approved reinvestment plans, or Reinvestment Funds in a plan submitted to DPW but which DPW has not taken a positive or negative action, remaining in the Primary Contractor’s Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for HC-BH transactions, must be returned to the Department within 14 months from the expiration of the Agreement.

I. In-Network Services

The Primary Contractor or its BH-MCO will be responsible for making timely payment for medically necessary, In-Plan Services.

1) In-Network Providers

The Primary Contractor or its BH-MCO will be responsible for making timely payment for medically necessary, In-Plan Services rendered by in-network Providers when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were rendered under the terms of the BH-MCO’s contract with the Provider; or

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

2) Out-of-Network Providers

The Primary Contractor or its BH-MCO will be responsible for making timely payments to Out-of-Network Providers for medically necessary, In-Plan Services when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were prior authorized by the BH-MCO; or

d. Medically necessary services were rendered during an emergency placement by the child welfare agency.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. The BH-MCO must assure that Out-of-Network Providers coordinate with respect to payment. The BH-MCO must assure that cost to Members is no greater than it would be if services were provided within the Provider network.

An Out-of-Network Provider, which is an enrolled MA Provider and which is billing the BH-MCO for covered HealthChoices In-Plan Services, shall not balance bill the Member.

An Out-of-Network Provider, which is not an enrolled Medicaid Provider, may balance bill the Member if the Member chose to receive service from that particular Provider. However, if the BH-MCO is referring a Member to an Out-of-Network Provider, the BH-MCO must pay deductibles and co-insurance up to the applicable Medical Assistance fee schedule amount for the service. In these circumstances, the Member cannot be subject to balance billing by the Provider.

3) Liability During an Active Provider Complaint

The Primary Contractor or its BH-MCO will not be liable to pay claims to Providers if the validity of the claim is being challenged by the BH-MCO through a Complaint process or appeal, unless the BH-MCO is obligated to pay the claim or a portion of the claim through its contract with the Provider.
J. Third Party Liability (TPL)

The Primary Contractor must comply with the Third Party Liability (TPL) procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C.A. 1396 (a)(25) and implemented by the Department. Under the Agreement, the Third Party Liability responsibilities of the Department will be allocated between the parties as indicated below.

1) Cost Avoidance Activities

   a. The Primary Contractor/ BH-MCO has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. 1396(a)(25) plans, and workers compensation. Except as provided in subparagraph 2 the Primary Contractor/ BH-MCO must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are available. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the appropriate HIPAA 837 Loop(s) for Medicare, and Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided. The Primary Contractor shall not be held responsible for any TPL errors in the Department's Eligibility Verification System (EVS) or the Department's TPL file.

   b. The Primary Contractor or its BH-MCO agrees to pay, and to require that its Subcontractors pay, all Clean Claims for Early Periodic Screening Diagnosis and Treatment (EPSDT) services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the Primary Contractor /BH-MCO is notified by the Department of such support orders or to the extent they become aware of such orders, and then seek reimbursement from liable third parties. The Primary Contractor or its BH-MCO shall communicate and encourage Providers to bill other primary insurance first, prior to submitting the claim to Medicaid. The Primary Contractor or its BH-MCO recognizes that cost avoidance of these claims is prohibited.

   c. The Primary Contractor or its BH-MCO may not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations. The Primary Contractor or its BH-MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third Party Liability is established at the time the claim is adjudicated.
2) Post-Payment Recoveries

a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) other resources. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The term “other resources” means all other resources and includes, but is not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all "other resources" as defined in paragraph 2)a. above. Any correspondence or inquiry forwarded to the Primary Contractor or its BH-MCO (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the consumer and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Primary Contractor or its BH-MCO 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 Commonwealth under the scope of these "other resources" shall be retained by the Commonwealth.

c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the Primary Contractor's/BH-MCO's untimely submission of notice of legal involvement where the Primary Contractor/BH MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Primary Contractor/BH-MCO. The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

d. The Primary Contractor or its BH-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of twelve (12) months from the date of payment. Notification of intent to pursue, collect and retain health-related claims not recovered by the Primary Contractor within the twelve (12) months from the date of payment will become the sole and exclusive right of the Department to pursue, collect and retain. The Primary Contractor is responsible to notify the Department of all cases recovered within the twelve (12) month period.
e. Should the Department lose recovery rights to any claim due to late or untimely filing of a claim with the liable third party, and the untimeliness in billing that specific claim is directly related to untimely submission of encounter data, additional records under special request, or inappropriate denial of claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable claim shall be assessed against the Primary Contractor/BH-MCO.

f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of sanctions against the Primary Contractor.

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

3) Health Insurance Premium Payment (HIPP) Program

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

The Department shall not purchase Medigap policies for equally eligible Members in the HealthChoices Zone.

4) Requests for Additional Data

The Primary Contractor/BH-MCO must provide, at the Department's request, such information not included in the encounter data submissions that may be necessary for the administration of TPL activity. The Primary Contractor/ BH-MCO shall use its best efforts to provide this information within fifteen (15) calendar days of the Department's request. There are certain Urgent requests involving cases for minors that require information within forty-eight (48) hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information shall be maintained as required by federal and state regulations.
5) Accessibility to TPL Data

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

6) Third Party Resource Identification

Third party resources identified by the Primary Contractor and/or its BH-MCO, which do not appear on the Department’s TPL database, must be supplied to the Department’s TPL Division by the Primary Contractor at least on a monthly basis. The method of reporting shall be via electronic or manual submission or by any alternative method approved by the Department. For electronic submissions, the Primary Contractor must follow the required report format, data elements, and specifications supplied by the Department. For manual submissions, the Primary Contractor must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department’s TPL Division will use these submissions for subsequent updates to the system.

The Primary Contractor shall use the Department’s verification systems (i.e. POSNET and EVS) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

7) Damage Liability

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

8) Estate Recovery

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

a. Public or private nursing facility services;

b. Residential care at home or in a community setting; or

c. Any hospital care and prescription drug services provided while receiving nursing facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.
K. Performance Management Information System and Reporting

1) General

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

To measure the Primary Contractor and its BH-MCO’s accomplishments in the areas of access to care, behavioral health outcomes, quality of life, and Member satisfaction, the Primary Contractor and its BH-MCO must provide the Department with uniform service utilization, Quality Management, and Member satisfaction/Complaint/Grievance data on a regular basis. The Primary Contractor and its BH-MCO also must cooperate with the Department in carrying out data validation steps. The Department intends to use this information as part of a collaborative effort with the Primary Contractor and its BH-MCOs to effect continuous quality improvement.

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

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

The Primary Contractor must, at its expense, arrange for a background check for each of its employees, as well as for the employees of its Subcontractors, who will have access to Commonwealth Information Technology (IT) facilities, either through on site or remote access. Background checks are to be conducted via the Request for Criminal Record Check form and procedure found at http://www.psp.state.pa.us/psp/lib/psp/sp4-164.pdf. The background check must be conducted prior to initial access by an IT employee and annually thereafter.

Before the Commonwealth will permit an IT Employee access to Commonwealth facilities, the Primary Contractor must provide written confirmation to the office designated by the agency that the background check has been conducted. If, at any time, it is discovered that an IT Employee has a criminal record that includes a felony or misdemeanor involving terrorist threats, violence, use of a lethal weapon, or breach of trust/fiduciary responsibility; or which raises concerns about building, system, or personal security, or is otherwise job-related, the Primary Contractor shall not assign that employee to any Commonwealth facilities, shall remove any access privileges already given to the employee, and shall not permit that employee remote access to Commonwealth facilities or systems, unless the agency consents, in writing, prior to the access being provided. The agency may
withhold its consent at its sole discretion. Failure of the Primary Contractor to comply with the terms of this paragraph may result in default of the Primary Contractor under its Agreement with the Commonwealth.


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

2) Management Information System

The Department requires an automated management information system (MIS). There are numerous components required for the complete system. They are service authorization, Member Complaint and Grievance, Provider Complaint, Provider profiling, claims processing including TPL identification, Member enrollment, financial reporting, Utilization Management, encounter data, performance outcomes, Quality Management, and suspected/substantiated fraud and abuse. Of these components, service authorization, Provider profiling, claims processing (including TPL) encounter data and Member enrollment must be integrated.

The Primary Contractor and its BH-MCO's MIS must be compatible with the Department's Pennsylvania Open Systems Network (POSNet) and have FTP connection capability with DPW’s PROMIsSe contractor, EDS (Electronic Data System).

The Primary Contractor and its BH-MCO must comply with the policy and procedures governing the operation of the Department's Pennsylvania Open Systems Network (POSNet), as defined in the document POSNet Interface Specifications contained in the HealthChoices Library.
The Primary Contractor and its BH-MCO must comply with all changes made to the POSNet Interface Specifications by DPW, or modifications made to the specifications by the Office of Medical Assistance or the Office of Mental Health and Substance Abuse Services.

The Primary Contractor or its BH-MCO is required to maintain an automated Provider directory. Upon request, the Primary Contractor or its BH-MCO is required to provide this directory to the Department via POSNet or via diskette.

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

3) Encounter and Alternative Payment Arrangements Data

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

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

The Department will validate the accuracy of data on the encounter and Alternative Payment Arrangement data files. Validation criteria are included for each data element in the Requirements and Specifications Manual for Encounter Data/Alternative Payment Arrangement Data and in the Aggregate Encounter and Complaint and Grievance Reporting Manuals, both of which are found in the HealthChoices Library.
a. 837 Transaction. The 837 Transaction must include, at a minimum, the data elements listed in the HIPAA Implementation Guides and PROMISe Companion Guides.

b. Aggregate Data. The aggregate data submittal must include, at a minimum, the data elements/reports listed in the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

c. Data Format. The Primary Contractor and its BH-MCO must agree to submit Encounter and Alternative Payment Arrangement data electronically to the Department through PROMISe using the FTP. Data file content must conform to the requirements specified in the HIPAA Implementation Guides and PROMISe Companion Guides and the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

d. Timing of Data Submittal.

An encounter must be submitted and pass PROMISe edits on or before the last calendar day of the third month after the Primary Contractor paid/adjudicated the encounter.

Acceptable Alternative Payment Arrangement (formerly known as subcapitation) data must be submitted and found acceptable to the Department within thirty (30) days after the period or case for which the payment applies.

The Primary Contractor must adhere to the file size specifications provided by the Department. A file submission schedule will be developed and provided to the Primary Contractor.

e. Member Medical Information

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

f. Data Validation

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

All costs incurred under the Agreement are subject to audit by the Department or its designee for final approval and acceptability, in accordance with industry standards, applicable accounting principles, and Federal and State regulations and policy. Additional information on auditing is contained in Appendix W and the HealthChoices Financial Reporting Requirements, (Appendix P), also available in the HealthChoices Library. The Primary Contractor is responsible to comply with audit requirements as specified in the HealthChoices Audit Clause (Appendix W).

M. Restitution

The Primary Contractor shall make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due to the Primary Contractor under this Agreement whether such overpayment is discovered by the Primary Contractor, the Department, or other third party.

N. Claims Processing and Management Information System (MIS)

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

. The Membership management system must have the capability to receive, update and maintain the BH-MCO's Membership files consistent with information provided by the Department.

. The claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this document. Claims history must be maintained with sufficient detail to meet all Department reporting and encounter requirements.

. The Provider file management system must have the capability to store information on each Provider sufficient to meet the Department's reporting requirements.

. The Primary Contractor or its BH-MCO must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.

. The Primary Contractor or its BH-MCO must have the capability to electronically transfer data files with the Department.
The Primary Contractor or its BH-MCO must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification Rule for the eight electronic transactions and for the code sets used in these transactions or there must be adequate documentation to demonstrate that the system will be compliant with the standards by October 16, 2003.

Primary Contractor or its BH-MCO must have a procedure for maintaining recipient enrollment and eligibility data, including a procedure for reconciliation of data discrepancies between their eligibility database and the Department’s EVS, CIS and daily and monthly eligibility file transfers.

The Primary Contractor or its BH-MCO's information system shall be subject to review and approval by the Department at any time.

O. Data Support

The Department will make files available to the Primary Contractor or its BH-MCO on a routine basis that will allow them to effectively meet their obligation to provide services and record information consistent with Agreement requirements (See Appendix O). The Department expects to provide daily and monthly eligibility files, TPL monthly files, monthly payment reconciliation and summary payment files, MCO Provider Error File, ARM 568 File, MA Provider File, Procedure Code, Diagnosis Code Files and quarterly BDAP CIS files.

P. Federalizing General Assistance (GA) Data Reporting

The Primary Contractor or its BH-MCO must submit a properly formatted monthly file to the Department regarding payments applicable to state-only general assistance (GA) Members. The file shall include data on hospital claims paid by the Primary Contractor during the reporting month. The files shall include data for three (3) types of hospital services as listed below:

- Admissions to inpatient psychiatric hospital
- Admissions to acute care hospitals
- Admissions to rehabilitation hospitals

The following types of information must be included in each record on the file:

- HMO code
- Provider
- Member
- Claim
- Additional data elements as required by Report #16 and Appendix P in the FRR.

Failure to comply with these requirements shall result in a penalty equal to three (3) times the amount that applies to other reporting requirements.
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ACCESS Plus - The Medical Assistance physical health care delivery system which is an Enhanced Primary Care Case Management and Disease Management Program providing services to eligible MA recipients not enrolled in a voluntary managed care organization in the 42 counties where HealthChoices Physical Health Mandatory Managed Care is not operational.

Adjudicate - A determination to pay or reject a claim.

Affiliate - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a Private Sector BH-MCO, including a Private Sector BH-MCO subcontracting with a county, Joinder, or Multi-County Entity, or a Private Sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the Private Sector BH-MCO's or Private Sector BH-MCO's parent(s), directors and subsidiaries of the Private Sector BH-MCO, shall be presumed to be Affiliates for purposes of this Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement – The HealthChoices Behavioral Health Agreement.

Alternative Payment Arrangements (APA) – Refers to any of the various contractual agreements for reimbursement that are not based on a traditional Fee-for-Service model. Types of arrangements include, but are not limited to the following: retainer payments; case rate; and Capitation.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of Behavioral Health Services under this Agreement.

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

Behavioral Health Residential Treatment Facility – An In-Plan Services mental health or drug and alcohol residential treatment facility.

Behavioral Health Services – Services that are provided to Members to treat mental health and/or substance abuse diagnoses/disorders.
Behavioral Health (BH) Services Provider - A Provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide Behavioral Health Services under the HealthChoices Behavioral Health Program.

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

Capitation - A fee the Department pays periodically to a Primary Contractor for each Member enrolled under an agreement for the provision of covered In-Plan Services, whether or not the Member received the services during the period covered by the fee.

Care Management/Manager - see Service Management/Manager.

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

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

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

Co-Occurring Disorder Professional – An individual who is certified by a state or national certification body to provide integrated co-occurring psychiatric and substance use treatment, or trained in a recognized discipline, including but not limited to psychiatry, psychology, social work, or addictions, and has one year of clinical experience in the treatment of co-occurring disorders.

Complaint – A dispute or objection filed with the BH-MCO regarding a participating health care Provider or the coverage, operations, or management policies of a BH-MCO, including, but not limited to, 1) a denial because the requested service is not a covered benefit; 2) failure of the BH MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a Complaint or Grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit. The term does not include a Grievance.
**Concurrent Review** - A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.

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

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

**Day** – A calendar day unless otherwise specified in the Agreement.

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

**Denial of Services** - A determination made by a BH-MCO in response to a Provider's or Member’s request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely, or
b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
c. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
d. reduces, suspends, or terminates a previously authorized service.

Note: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

i) The service requested is not a covered service.
ii) The service requested is a covered service but not for this particular recipient (due to age, etc.)
iii) The information provided is insufficient to determine that the service is Medically Necessary.
iv) The service requested is not Medically Necessary.

**Department/DPW** - The Pennsylvania Department of Public Welfare.
*Department of Public Welfare Fair Hearing* - A hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals in response to an appeal by a Member.

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

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

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

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

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

*Emergency Services* - Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services under the Medical Assistance Program and which are needed to evaluate or stabilize an Emergency Medical Condition.

*Enrollment Assistance Program (EAP)* - The program responsible to assist MA recipients in enrolling in the HC Program, including the selection of a PH-MCO and Primary Care Practitioner, and obtaining information regarding the HC physical and behavioral health programs.

*Enrollment Specialist* - The EAP individual who will be responsible to assist recipients with selecting a PH-MCO and Primary Care Practitioner, and providing information about the HealthChoices PH Program.

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

*Fee-for-Service (FFS)* - Payment by the Department to Providers on a per-service basis for health care services provided to Medical Assistance recipients.
Federally Qualified Health Clinic (FQHC/ Rural Health Clinic (RHC)) – An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. §1396d(1) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under 42 U.S.C.A. §1396d(1).

Grievance - A request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or in part, payment for a service if based on lack of Medical Necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service.

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

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

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

HealthChoices Behavioral Health (HC-BH) Program – The mandatory managed care program which provides Medical Assistance recipients with Behavioral Health Services in the Commonwealth.

HealthChoices Physical Health (HC-PH) Program – The mandatory managed care program which provides Medical Assistance recipients with physical health services in the Commonwealth.


HealthChoices Zone (HC Zone) – County groupings designated by the Department for participation in the HC-BH Program.

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

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

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

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

- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;

- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and

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

**Managed Care Organization (MCO)** - An entity which manages the purchase and provision of physical or Behavioral Health Services under the HC Program.

**MCO Assessment** - An assessment imposed upon the revenues of DPW’s Medicaid managed care organizations pursuant to 62 P.S. §801-B et seq.

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

- prevent the onset of an illness, condition, or disability;

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

*Member (Enrollee)* - A Medicaid or Medical Assistance recipient who is currently enrolled in the HC-BH Program.

*Member Month* - One Member covered by the HC-BH Program for one month.

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

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

*Multi-County Entity* – Two or more counties which form a legally binding incorporated entity, such as a 501c (3), which has established Articles of Incorporation and intergovernmental agreements and has a single Agreement with the Department. This entity is established for the purpose of offering Behavioral Health Services for Medicaid eligible recipients under the HealthChoices Program as a Primary Contractor.

*On-Site Reviews* - A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor to accept Members and to manage and administer the purchase and provision of Behavioral Health Services under this Agreement.

*Out-of-Area Services* - In-Plan Services provided to a Member while the Member is outside the HealthChoices Zone.

*Out-of-Network Provider* - A Behavioral Health Services Provider who does not have a written Provider Agreement with the BH-MCO and is therefore not included or identified as being in the BH-MCO's Provider network.

*Parent* - The biological or adoptive mother or father, or the legal guardian of the child, or a responsible relative or caretaker (including foster Parents) with whom the child regularly resides.
Physical Health Managed Care Organization (PH-MCO) - An entity which has contracted with the Department to manage the purchase and provision of physical health services under the HC Program.

Physical Health Service System (PHSS) – any system by which a Medical Assistance recipient receives physical health services (e.g. Fee-for-Service, HealthChoices-Physical Health, Voluntary MCOs and ACCESS Plus)

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

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

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

Primary Contractor - A county, Multi-County Entity, or a BH-MCO which has a HealthChoices Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

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

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

Prior Authorized Services - In-Plan Services for which a BH services Provider must obtain, pursuant to Department approved BH-MCO policies and procedures, the BH-MCO's approval in advance of the Provider's initiating provision of the service.

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

*Private Sector BH-MCO* - A Commonwealth licensed BH-MCO which has contracted with the Department or county government to manage the purchase and provision of Behavioral Health Services under this document.

*PROMISe* – (Provider Reimbursement and Operations Management Information System) is the HIPAA-compliant claims processing and management information system implemented by the Department in March 2004.

*Provider* – An individual, firm, corporation, or other entity which provides behavioral health or medical services or supplies to Medical Assistance recipients.

*Provider Agreement* - Any written agreement between the BH-MCO and a Provider or DPW and a Provider to render clinical or professional services to recipients to fulfill the requirement of the Agreement.

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

*Reinvestment Funds* - Capitation revenues from DPW and investment income which are not expended during an Agreement year by the Primary Contractor for purchase of services for Members, administrative costs, and equity requirements but may be used in a subsequent Agreement year to purchase start-up costs for In-Plan Services, development or purchase of Supplemental Services or non-medical services, contingent upon DPW prior approval of the Primary Contractor’s reinvestment plan.

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

1. Performs some of the Primary Contractor's management functions under contract or delegation; or

2. Furnishes services to Members under a written agreement; or

3. Leases real property or sells materials to the Primary Contractor at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

*Retrospective Review* - A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO's payment policies and procedures.
**Risk Assuming PPO** - A Commonwealth licensed PPO which meets the definition of a Risk Assuming PPO pursuant to regulations at 31 Pa. Code Subsection 152.2.

**Rural** - Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons, as defined by the US Census Bureau.

**Service Management/Manager** - The BH-MCO function/staff with responsibility to authorize and coordinate the provision of In-Plan Services. Care Management/Manager is synonymous.

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

**Start Date** - The first date on which Members are eligible for Behavioral Health Services under the Agreement, and on which the Primary Contractor is at risk for providing Behavioral Health Services to Members.

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

**Subcontractor** – Any person or entity other than the Primary Contractor who enters into a Subcontract.

**Supplemental Services** – MA eligible mental health and drug and alcohol services purchased in lieu of or in addition to an In-Plan Service.

**Third Party Liability (TPL)** – Any individual, entity, (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Member’s health care expenses.

**Title XVIII (Medicare)** - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

**Urban** - Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more, as defined by the US Census Bureau.

**Urgent** - Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.
Utilization Management - The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

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

Women’s Business Enterprise- A small business concern which is: a sole proprietorship, owned and controlled by a woman; a partnership or joint venture controlled by women in which at least 51% of the beneficial ownership interest is held by women; or a corporation or other entity controlled by women in which at least 51% of the voting interest and 51% of the beneficial ownership interest is held by women.
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>APA</td>
<td>Alternative Payment Arrangement</td>
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<tr>
<td>APD</td>
<td>Advanced Planning Document</td>
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<tr>
<td>ARD</td>
<td>Accelerated Rehabilitation Decision</td>
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<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
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<tr>
<td>ASCII</td>
<td>American Standard Code for Information Interchange</td>
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<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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<tr>
<td>BDAP</td>
<td>Bureau of Drug and Alcohol Programs</td>
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<tr>
<td>BDAP CIS</td>
<td>Bureau of Drug and Alcohol Programs’ Client Information System</td>
</tr>
<tr>
<td>BMWBO</td>
<td>Bureau of Minority and Women Business Opportunities</td>
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<tr>
<td>BEC</td>
<td>Basic Education Circular</td>
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<tr>
<td>BHEF</td>
<td>Behavioral Health Encounter File</td>
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<tr>
<td>BH-MCO</td>
<td>Behavioral Health Managed Care Organization</td>
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<tr>
<td>BHRS</td>
<td>Behavioral Health Rehabilitation Services for Children and Adolescents</td>
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<tr>
<td>BIS</td>
<td>Bureau of Information Systems</td>
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<tr>
<td>BNDD</td>
<td>Bureau of Narcotic Drugs and Devices</td>
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<tr>
<td>BSU</td>
<td>Base Service Unit</td>
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<tr>
<td>CAO</td>
<td>County Assistance Office</td>
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<tr>
<td>CASSP</td>
<td>Child and Adolescent Service System Program</td>
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<tr>
<td>CAU</td>
<td>County Administrative Unit</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>CCRS</td>
<td>Consolidated Community Reporting System</td>
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<tr>
<td>CCYA</td>
<td>County Children and Youth Agency</td>
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<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
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<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>C/FST</td>
<td>Consumer/Family Satisfaction Team</td>
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<tr>
<td>CHADD</td>
<td>Children with Attention Deficit Disorders</td>
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<tr>
<td>CIS</td>
<td>Client Information System</td>
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<tr>
<td>CISC</td>
<td>Children and Adolescents in Substitute Care</td>
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<tr>
<td>CLIA</td>
<td>Clinical Laboratory Improvement Amendment</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
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<tr>
<td>CRD/LIC</td>
<td>Credentials/license</td>
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<tr>
<td>CRCS</td>
<td>Capitation Rate Calculation Sheet</td>
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<tr>
<td>CRF</td>
<td>Consumer Registry File</td>
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<tr>
<td>CRNP</td>
<td>Certified Registered Nurse Practitioner</td>
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<td>CRR</td>
<td>Community Residential Rehabilitation</td>
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<tr>
<td>CSI</td>
<td>Consumer Satisfaction Instruments</td>
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<td>CSP</td>
<td>Community Support Program</td>
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<td>CST</td>
<td>Consumer Satisfaction Team</td>
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<td>DAP</td>
<td>Disability Advocacy Program</td>
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<tr>
<td>D&amp;A</td>
<td>Drug and Alcohol</td>
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<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ICF/MR</td>
<td>Intermediate Care Facilities for Persons with Mental Retardation</td>
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<tr>
<td>ID</td>
<td>Insurance Department</td>
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<tr>
<td>IFB</td>
<td>Invitation for Bid</td>
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<td>IMD</td>
<td>Institution for Mental Disease</td>
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<tr>
<td>ISP</td>
<td>Individualized Service Plan</td>
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<tr>
<td>JDC</td>
<td>Juvenile Detention Center</td>
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<td>JPO</td>
<td>Juvenile Probation Office</td>
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<tr>
<td>L/C</td>
<td>Lehigh/Capital</td>
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<tr>
<td>LTC</td>
<td>Long Term Care</td>
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<tr>
<td>MA</td>
<td>Medical Assistance</td>
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<td>MATP</td>
<td>Medical Assistance Transportation Program</td>
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<tr>
<td>MBE</td>
<td>Minority Business Enterprise</td>
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<tr>
<td>MBE/WBE</td>
<td>Minority Business Enterprise/Women Business Enterprise</td>
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<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MR</td>
<td>Mental Retardation</td>
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<td>MOE</td>
<td>Method of Evaluation</td>
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<td>MPL</td>
<td>Minimum Participating Levels</td>
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<tr>
<td>NCE</td>
<td>Non-Continuous Eligibility</td>
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<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NDC</td>
<td>National Drug Code</td>
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<td>NE</td>
<td>Northeast</td>
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</table>
NMP Non-money payment
OBRA Omnibus Budget Reconciliation Act
OCYF Office of Children, Youth & Families
OIP Other Insurance Paid
OMAP Office of Medical Assistance Programs
OMHSAS Office of Mental Health and Substance Abuse Services
OMR Office of Mental Retardation
ORC Other Related Conditions
OSP Office of Social Programs
OTC Over The Counter
PCIS Patient Census Information System
PCP Primary Care Practitioner
PCPC Pennsylvania Client Placement Criteria
PDA Pennsylvania Department of Aging
PH-MCO Physical Health Managed Care Organization
PHSS Physical Health Service System
PIHP Prepaid Inpatient Health Plan
PIN Parents Involved Network
PMPM Per Member Per Month
POM Performance Outcome Measures
POMS Performance Outcome Management System
POSNet Pennsylvania Open Systems Network
PPO Preferred Provider Organization
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>PROMISe</td>
<td>Provider Reimbursement and Operations Management Information System electronic</td>
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<tr>
<td>PRTF</td>
<td>Psychiatric Residential Treatment Facility</td>
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<tr>
<td>QARI</td>
<td>Quality Assurance Reform Initiative</td>
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<tr>
<td>QM</td>
<td>Quality Management</td>
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<td>QMB</td>
<td>Qualified Medicare Beneficiaries</td>
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<td>QSF</td>
<td>Quarterly Status File</td>
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<td>RBUC</td>
<td>Received But Unpaid Claims</td>
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<td>RHC</td>
<td>Rural Health Clinic</td>
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<tr>
<td>RTF</td>
<td>Residential Treatment Facility</td>
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<td>SAP</td>
<td>Statutory Accounting Principles</td>
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<td>SBP</td>
<td>State Blind Pension</td>
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<td>SCA</td>
<td>Single County Authority</td>
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<td>SE</td>
<td>Southeast</td>
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<td>SMH</td>
<td>State Mental Hospital</td>
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<td>SMM</td>
<td>State Medicaid Manual</td>
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<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<td>SNU</td>
<td>Special Needs Unit</td>
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<td>SPR</td>
<td>System Performance Review</td>
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<td>SSA</td>
<td>Social Security Administration</td>
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<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>SSN</td>
<td>Social Security Number</td>
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<tr>
<td>SUR</td>
<td>Surveillance and Utilization Review</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SURS</td>
<td>Surveillance and Utilization Review System</td>
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<tr>
<td>SW</td>
<td>Southwest</td>
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<td>TANF</td>
<td>Temporary Assistance to Needy Families</td>
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<td>TPL</td>
<td>Third Party Liability</td>
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<tr>
<td>TTY</td>
<td>Text Telephone Typewriter</td>
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<tr>
<td>UM</td>
<td>Utilization Management</td>
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<tr>
<td>UM/QM</td>
<td>Utilization Management/Quality Management</td>
</tr>
<tr>
<td>UPIN</td>
<td>Unique Physician Identification Number</td>
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<tr>
<td>USC</td>
<td>United States Code</td>
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<tr>
<td>WBE</td>
<td>Women’s Business Enterprise</td>
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PART I. GENERAL INFORMATION

I-1. PURPOSE

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

The purpose of this document is to set forth the standards for the HC-BH Program operating under the Centers for Medicare and Medicaid Services Waiver of Section 1915(b) of the Social Security Act, for licensed, risk assuming Private Sector Behavioral Health Managed Care Organizations (BH-MCOs) that are Primary Contractors to manage the purchase and provision of Behavioral Health Services in the Commonwealth of Pennsylvania’s (hereinafter referred to as the Commonwealth) mandatory managed care program called HealthChoices for eligible MA recipients residing in the North/Central zone of Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntington, Jefferson, McKean, Juniata, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties.

Within this 23 county geographic area Bradford/Sullivan, Cameron/Elk, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, and Huntingdon/Mifflin/Juniata counties are organized as Joinders for the delivery of county-administered mental health and drug and alcohol services.

I-2. ISSUING OFFICE

This document is issued by the Office of Mental Health and Substance Abuse Services.

I-3. SCOPE

This document describes Behavioral Health Services standards and requirements with which the Primary Contractor must comply. It also includes information on the policies and procedures the Department will follow in carrying out its program management and oversight responsibilities.

A county is the smallest geographic unit for which the Department enters into a HealthChoices behavioral health contract, and the Primary Contractor must be capable of delivering specified services to all Members in the county. The Department will contract with and conduct all business through the Primary Contractor.
I-4. **TYPE of AGREEMENT**

The Department enters into a full-risk capitated Agreement using a flat fee per Member in the HC-N/C counties. The Primary Contractor is responsible for all medically necessary In-Plan Services. Should the Primary Contractor incur costs that exceed the Capitation payments, the Department will not be responsible for providing additional funds to cover the deficits. The method of payment is monthly; however, payments will be delayed by two months. Example: The program starts on January 1, 2007; the Capitation payment for the month of January 2007 will be made on or before March 15, 2007. The two month payment delay will be reconciled upon termination of the Agreement.

The Agreement is for 42 months, ending June 30, 2010. Subject to the availability of state and federal funds, the Department reserves the right to renew the Agreement for one additional two-year period. During this renewal period, payment for services will continue to follow the two month delay. The Department will notify the Primary Contractor of its intention to renew prior to the expiration of the Agreement.

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

Requirements of this document are a part of the Agreement and are not subject to negotiations by the Primary Contractor. The Department will develop a transition plan should it choose to cancel or not to extend a contact with the Primary Contractor operating the behavioral health program.

I-5. **ON-SITE REVIEWS**

The Department periodically conducts On-Site Reviews of the Primary Contractors and Subcontractors. The purpose of an On-Site Review is to determine the Primary Contractor's initial and on-going compliance with respect to meeting work statement tasks and requirements. The Department has the sole option to suspend or terminate implementation of the Agreement and/or Member enrollment for any Primary Contractor that does not demonstrate to the Department's satisfaction, compliance with any critical program standard.

I-6. **HEALTHCHOICES RATE INFORMATION**

The Department releases historical cost data by rating group and category of service for the various HealthChoices Zones. Additional data and/or information may also be provided to assist the Primary Contractor in constructing or responding to a Capitation rate proposal.
I-7. **INCURRING COSTS**

The Department is not liable for any costs incurred by the Primary Contractor prior to the effective date of the Agreement.

I-8. **HEALTHCHOICES LIBRARY**

Documents relevant to the HealthChoices Program are available for review at the Office of Mental Health and Substance Abuse Services, Beechmont Building, Second Floor, 21 Beech Street, Harrisburg, PA 17110-3591. The documents available from the Department include but are not limited to those documents listed in Appendix DD.

I-9. **RESPONSIBILITY TO EMPLOY WELFARE WORKERS**

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

I-10. **DISADVANTAGED BUSINESS INFORMATION**

The Commonwealth encourages participation by small disadvantaged businesses as prime contractors, joint ventures and Subcontractors/suppliers and by socially disadvantaged businesses as prime contractors.

Small Disadvantaged Businesses are small businesses that are owned or controlled by a majority of persons, not limited to members of minority groups, who have been deprived of the opportunity to develop and maintain a competitive position in the economy because of social disadvantages. The term includes: (1) Department of General Services Bureau of Minority and Women Business Opportunities (BMWBO)-certified Minority Businesses Enterprises (MBEs) and Women’s Business Enterprises (WBEs) that qualify as small businesses and (2) United States Small Business Administration-certified small disadvantaged businesses or 8(a) small disadvantaged business concerns.

Small businesses are businesses in the United States that are independently owned, are not dominant in their field of operation, employ no more than 100 persons and earn less than $20 million in gross annual revenues ($25 million in gross annual revenues for those businesses in the information technology sales or service business).

Socially disadvantaged businesses are businesses in the United States that BMWBO determines are owned or controlled by a majority of persons, not limited to members of minority groups, who are subject to racial or ethnic prejudice or cultural bias, but which do not qualify as small businesses. In order for a business to qualify as "socially disadvantaged", the proposer must include in its proposal clear and convincing evidence to establish that the business has personally suffered racial or ethnic prejudice or cultural bias stemming from the business person's color, ethnic origin or gender.
I-11. PRIMARY CONTRACTOR RESPONSIBILITIES

The Primary Contractor is required to assume responsibility for all services offered in this document and Agreement whether it directly provides or contracts for the provision of the services. Further, the Department will consider the Primary Contractor to be the sole point-of-contact with regard to Agreement matters. If Subcontractors are used, the Primary Contractor will be responsible for the Subcontractor’s performance.

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

Office space, equipment, and logistical support are the responsibility of the Primary Contractor. The BH-MCO's administrative offices, from which the program is operated, must be located within the Commonwealth of Pennsylvania and ensure maximum efficiency of administrative cost while being responsive to the counties and Members in the N/C zone.

I-12. FREEDOM OF INFORMATION AND PRIVACY ACTS

The Primary Contractor should be aware that all materials associated with this document are subjected to the terms of the Freedom of Information Act (5 U.S.C. Section 552 et seq.), the Privacy Act of 1974 (5 U.S.C. Section 552a), the Right-to-Know Law (65 P.S. Section 66.1 et seq.) and all rules, regulations, and interpretations of these acts, including those from the offices of the Attorney General of the United States, Health and Human Services (HHS), and the Centers for Medicare and Medicaid Services (CMS).

I-13. NEWS RELEASES

News releases will not be made without prior Commonwealth approval, and the only in coordination with the Department.

I-14. COMMONWEALTH PARTICIPATION

The Department's Office of Mental Health and Substance Abuse Services (OMHSAS) provides the Project Office for formal oversight of the HC-BH program. The OMHSAS, in collaboration with the Department's Office of Medical Assistance Programs (OMAP) and the Department of Health's Bureau of Drug and Alcohol Programs (BDAP), provides responses to requests for clarification and questions. The Department will not provide office space, reproduction facilities, or other logistical support to any Primary Contractor. The Department provides enrollment and disenrollment activities for the HealthChoices Program by contract as described in the Enrollment Assistance Program (HealthChoices Library).
I-15. **PROJECT MONITORING**

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

In addition to Department oversight, CMS may also monitor the HC-BH Program through its regional office in Philadelphia, Pennsylvania, and its Office of Managed Care in Baltimore, Maryland.

I-16. **CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS**

The Primary Contractor certifies it is not currently under suspension or debarment by the Commonwealth, any other state, or the federal government. If the Primary Contractor enters into contracts or employs under this Agreement any Subcontractors/individuals currently suspended or debarred by the Commonwealth or the federal government or who become suspended or debarred by the Commonwealth or federal government during the term of this Agreement or any extensions or renewals thereof, the Commonwealth shall have the right to require the Primary Contractor to terminate such Subcontracts or employment.

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

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

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

The Primary Contractor agrees that the Commonwealth may offset the amount of any state tax liability or other debt of the Primary Contractor or its subsidiaries owed to the Commonwealth and not contested on appeal against any payment due the Primary Contractor under this or any other contract with the Commonwealth.
I-17. LOBBYING CERTIFICATION AND DISCLOSURE

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant or cooperative agreement exceeding $100,000, or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. See Lobbying Certification Form and Disclosure of Lobbying Activities Form attached as Appendix D.

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

I-18. CONTRACTOR’S CONFLICT OF INTEREST

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

I-19 PROHIBITED AFFILIATIONS WITH INDIVIDUAL DEBARRED AND FEDERAL AGENCIES

The Primary Contractor may not knowingly have a relationship with the following:

A. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

B. An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (A) above.

For the purpose of this section, “relationship” means the following:

- A director, officer or partner of the Primary Contractor.
- A person with beneficial ownership of five percent (5%) or more of the Primary Contractor’s equity.
- A person with employment, consulting or other arrangement with the Primary Contractor’s obligations under this Agreement.
I-20. CHANGE TO CERTAIN APPENDICES

The following appendices may be updated, from time to time, by the Department through issuance of an operations memo, and/or policy clarification and do not require an amendment to this Agreement to be effective and enforceable:

Appendix L: Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys
Appendix N: HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans
Appendix P: The HealthChoices Behavioral Health Financial Reporting Requirements
Appendix V: The HealthChoices Behavioral Health Recipient Coverage Document
Appendix Y: The HealthChoices Behavioral Health Services Reporting Classification Chart
PART II. WORK STATEMENT

II-1. OVERVIEW

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

II-2. OBJECTIVES

A. General

The Department is interested in working with private sector BH-MCOs to administer the mandatory HC-BH Program in the North/Central zone.

B. Specific Objectives

The HC-BH Program provides for the delivery of medical necessary mental health, drug and alcohol, and behavioral services. Specific objectives are:

1) Structure Objectives
   a. To have the Department contract directly with a Private Sector BH-MCO to manage the purchase and provision of Behavioral Health Services in the N/C zone and to manage any additional counties identified by the Department in the future.
   b. To include county government in the N/C zone as partners with the Department in the oversight of the program.
   c. To develop alternative cost effective services and opportunities for shared reinvestment among counties served.

2) Program Objectives
   a. To promote resiliency-oriented and recovery-oriented best-practices that are cost effective.
   b. To create systems of care management that are developed based on input from and responsive to the needs of consumers, persons in recovery, and their families representative of the various cultures and ethnic groups in the county, who depend on public services.
c. To provide incentives to implement Utilization Management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care, and increasing prevention and early diagnosis and treatment.

d. To promote partnerships between the public and private sectors that take advantage of the public sector's experience in serving persons with the most serious illnesses and disabilities who often have few resources and supports, and the private sector's expertise in managing financial risk for Behavioral Health Services.

e. To remove incentives to shift costs between behavioral health and other publicly funded human service and correctional programs.

f. To create geographic service areas of optimal size for managing risk under Capitation financing which allow for regional variations in program design and result in administrative cost savings.

g. To develop consumer and family satisfaction mechanisms in partnership with consumers, persons in recovery, and their families representative of the diverse ethnic, cultural and disability groups in the county who are affected by mental illness and addictive diseases.

h. To improve coordination of substance abuse and mental health services, including the development of specialized programs for persons with both psychiatric and substance abuse disorders.

i. To create new integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children and adolescents, including coordination with early intervention and early childhood care and education programs.

j. To shift the focus of state monitoring from process management to outcome management with an emphasis on reduction of out-of-home placements for children and adolescents, increased community tenure, improved health status, and improved vocational and educational functioning.

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

l. To improve coordination of care between physical and Behavioral Health Services including disease management, programs to improve health outcomes, educate consumers and Providers, and increase access to Providers.
II-3. **Nature and Scope of the Project**

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

A. **Enrollment**

1) **HealthChoices Behavioral Health Care**

Members are enrolled in the BH-MCO operating in their county of residence upon being determined eligible for Medical Assistance. As Members are enrolled information will be forwarded to the BH-MCO. The BH-MCO must establish mechanisms to inform the County Assistance Office of any change or update to the Member’s residency or eligibility status within 10 days of the date of learning of the change.

The Department has sole authority for determining whether individuals or families meet eligibility criteria. The Department performs eligibility determinations using trained staff in County Assistance Offices (CAOs) located throughout the Commonwealth.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing Behavioral Health Services for newly enrolled Members. The Department will provide the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine periods of coverage and responsibility for services.

B. **HealthChoices Program Eligible Groups**

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

1) The eligible groups (see Appendix X for details) are:

a. **Temporary Assistance to Needy Families (TANF) and TANF-Related MA:** A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment), to families which contain dependent children who are deprived of the care or support of one or both Parents due to absence, incapacity, or unemployment of a Parent.

c. Healthy Horizons: An MA program which provides non-money payment (NMP) MA and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. Exception: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC-BH-N/C Program.

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

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

e. SSI-Related: An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.

f. State-Only GA: A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

g. Federally-Assisted MA for GA Recipients: A federal and state funded program which provides MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

2) Eligibility Determination

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

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through the last day of the month in which the 60 days postpartum or post-loss of pregnancy period ends and their newborns are guaranteed coverage for one year, as long as mother and child continue to live together during that year.

4) Involuntary Mental Health Commitment

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

5) Placement of Adults and Children NOT in Substitute Care in Behavioral Health Residential Treatment Facilities (see Appendix V – H.).

6) Children and Adolescents in Substitute Care Issues (see Appendix V – H.)

7) For children and adolescents placed in a juvenile detention facility, the BH-MCO is responsible for medically necessary In-Plan Services delivered in treatment settings outside (off site) the juvenile detention facility during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.

8) Children whose adoptions have been finalized and for whom the CCYA is continuing to provide support through an adoption assistance agreement with the adoptive Parents residing in the HC Zone, are to be enrolled in the BH-MCO of the county where the adoptive family resides.

9) The BH-MCO will be required to pay for medically necessary Behavioral Health Services for Members provided within a private ICF/MR facility within the HC Zone.

10) In order to serve an individual less than 21 years of age in a psychiatric hospital setting and be reimbursed through Medical Assistance for the service, the facility must be JCAHO accredited according to Federal Regulations, 42 CFR Subpart D §441 relating to Individual Under Age 21 in Psychiatric Facilities or Programs, at 42 CFR §441.151 (a) (2).
C. Rating Period

A rating period coincides with the term of an Agreement, i.e., the period for which Capitation rates are developed and instituted for each year of the Agreement. Capitation cost proposals apply of the initial rating period.

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

1) Changes in medical costs;
2) Changes in utilization patterns; or
3) Programmatic changes that affect the Primary Contractor’s delivery or coverage of benefits.

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

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

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

D. Termination/Cancellation

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

DPW requires the Primary Contractor to provide a minimum of 120 day notice of intent to terminate the Agreement. Upon termination/Cancellation or expiration of the Agreement, the Primary Contractor must:

1) Provide the Department with all information deemed necessary by the Department within 30 days of the request;
2) Be financially responsible for Provider claims with dates of service through the day of termination, except as provided in D.3) below, including those submitted within established time limits after the day of termination;
3) Be financially responsible for Members placed in inpatient and residential treatment facilities through the dates specified in Section E of the HC-BH-N/C Recipient Coverage Document (Appendix V).

4) Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in D.3) above, for which payment is denied by the BH-MCO and subsequently approved upon appeal by the Provider; and

5) Arrange for the orderly transition of Members and records to those Providers who will be assuming ongoing care for the BH-MCO Members.

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

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

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


F. False Claims

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

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

H. Performance Standards and Damages

1) Performance Standards for the HC-BH Program

Performance standards for the HC-BH Program are included throughout this document. Additional standards may be developed, prior to the implementation of the HC-BH-N/C Program, for inclusion in subsequent related Agreements. The Primary Contractor may develop performance standards consistent with this document. The Department reserves the right to institute incentive payments related to performance standards in the future.

2) Sanctions and Penalties

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

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

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

3) Profit and Reinvestment Arrangement

a. Plans for shared reinvestment must be priorities for the unmet and under met needs of MA recipients as described in Appendix N. The Primary Contractor will establish a Reinvestment Fund which will hold funds available for shared reinvestment opportunities in the counties being served under the DPW Primary Contractor Agreement. See Appendix 5 to the Agreement for details related to the calculation of Reinvestment Funds.
b. BH-MCOs as Primary Contractors to DPW are permitted to retain profit. Profit will be monitored by DPW and will be a factor in future rate adjustments and negotiations.

II-4. TASKS

A. In-Plan Services

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

1) The Primary Contractor shall provide timely access to diagnostic, assessment, referral, and treatment services for Members for the following benefits:

a. Inpatient psychiatric hospital services, except when provided in a state mental hospital.
b. Inpatient drug and alcohol detoxification.
c. Psychiatric partial hospitalization services.
d. Inpatient drug and alcohol rehabilitation.
e. Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence.
f. Psychiatric outpatient clinic, licensed psychologist and psychiatrist services.
g. Behavioral health rehabilitation services (BHRS) for children and adolescents with psychiatric, substance abuse or mental retardation disorders.
h. MH residential treatment services for children and adolescents (accredited and non-accredited).
i. Outpatient D&A services, including Methadone Maintenance Clinic.
j. Methadone, when used to treat narcotic/opioid dependency and dispensed by an In-Plan drug and alcohol services Provider.
k. Clozapine support services.
l. Laboratory and diagnostic studies and procedures for the purposes of determining response to behavioral health medication and/or treatment ordered by Behavioral Health Services Providers acting within the scope of their license.
m. Crisis intervention services (telephone and mobile with in-home capability).
n. Family-based mental health services for children and adolescents.
o. Targeted mental health case management (intensive case management and resource coordination).
p. Mobile Mental Health Treatment
q. Peer Support Services
r. Psychiatric Rehabilitation Services, contingent upon approval from CMS of a State Plan Amendment (Please Note: The PC will be notified of the effective date when these services are approved by CMS).
s. Outpatient Drug and Alcohol Rehabilitation Services, contingent upon approval from CMS of a State Plan Amendment (Please Note: The PC will be notified of the effective date when these services are approved by CMS).

2) The Primary Contractor must require that network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service, if the Provider serves only Medicaid Members. Hours of operation should be flexible in order to accommodate the particular scheduling needs of Members (i.e. inclusion of evening and/or weekend hours)

3) The Primary Contractor must have procedures for authorization and payment for In-Plan Services, which are required but not available within the Provider network or for providing Emergency Services for Members who are temporarily out of the HC Zone.
   a. A Primary Contractor that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service, is not required to do so if it objects to the service on moral or religious grounds.
   b. If the Primary Contractor elects not to provide, arrange for the provision of, or make payment for a counseling or referral service because of an objection on moral or religious grounds, it must:
      • furnish information to the Department describing the service;
      • include this information with its application for a Medicaid contract;
      • notify the Department whenever it adopts the policy during the term of the Agreement;
      • notify Members within 30 days of adopting this policy and identify the excluded service(s); and,
      • be consistent with the provisions of 42 CFR 438.10.

4) Member Liability
   a. Members will not be held liable for:
      i. In-Plan Services provided to the Member for which the Department does not pay the Primary Contractor.
      ii. In-Plan Services provided to the Member for which the Department does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.
      iii. In-Plan Services to the extent that those payments are in excess of the amount that the Member would owe if the Primary Contractor provided the services directly.
b. In situations where a network Provider is not available to provide an In-Plan Service, the Primary Contractor must have procedures to coordinate with Out-of-Network Providers and must ensure that cost to the Members (if any) is no greater than it would be if the services were furnished by a network Provider.

5) The Primary Contractor is encouraged to develop and purchase cost effective Supplemental Services which can be provided in a less restrictive setting and/or which would result in improved outcomes for Members.

6) The Primary Contractor must provide comprehensive Service Management, with clear access and lines of authority. Each Member's plan of care, including the commencement, course, and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination with services covered by the Primary Contractor.

7) For Priority Populations, a clearly defined program of care which incorporates longitudinal and disease state management is expected. In addition, evidence of a coordinated approach must be demonstrated for those persons with: co-existing mental health and drug and alcohol conditions, older adults with psychiatric and substance use disorders (particularly those with co-existing physical impairments) and other Special Needs Populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, persons diagnosed with ASD, persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities).

8) The Primary Contractor is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.

   a. There must be 24 hour capacity for service authorization.
   b. There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
   c. All Member and Provider calls must be answered within 30 seconds.
   d. Separate Member and Provider telephone lines are permitted.
   e. The Member line must be answered by a live voice at all times.
   f. A Primary Contractor serving multiple counties in a HC-BH zone may establish a regional network with one telephone line for Member calls and one line for Provider calls.
   g. Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.

9) The Primary Contractor must have procedures for reminders, follow-up, and outreach to Members including:

   a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.
b. Population groups with special needs and/or groups who under use needed Behavioral Health Services, such as older persons, persons who are homebound or homeless and adults with mental retardation, and persons diagnosed with ASD.

c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

10) The Primary Contractor must have procedures to determine the EPSDT screen status for children receiving Behavioral Health Services. Referral to the child’s PCP must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The Primary Contractor must have procedures to collect and report EPSDT screen referral and status information.

B. Coordination of Care

1) The Primary Contractor is required to develop and implement written agreements with Physical Health Service Systems (PHSS) regarding the interaction and coordination of services provided to Members. These agreements must be submitted to and approved by the Department. A sample PH-BH coordination agreement (which does not include all required procedures) is in the HealthChoices Library. Complete agreements, including operational procedures, must be available for review by the Department at the time of On-Site Reviews. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the HC-BH-N/C Program. The written agreements should include, but not be limited to:

a. Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services, and other treatment issues necessary for optimal health and prevention of illness or disease. The PHSS and the Primary Contractor must collaborate in relation to the provision of Emergency Services; however, Emergency Services provided in general hospital emergency rooms are the responsibility of the Member’s PHSS, regardless of the diagnosis or services provided. The only exception is for emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the Primary Contractor. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis. Procedures must define and explain how payment will be shared when the Member's Primary Diagnosis changes during a continuous hospital stay.

b. Procedures, including Prior Authorization, which govern reimbursement by the Primary Contractor to the PHSS for Behavioral Health Services provided by the PHSS, or reimbursement by the PHSS to the Primary Contractor for physical health services provided by the Primary Contractor, and the resolution of any payment disputes for services rendered. Procedures must include provisions for assessment of persons with co-existing physical and behavioral health disorders, as
c. Procedures for the exchange of relevant enrollment and health-related information among the Primary Contractor, the PHSS, the PCP, and BH and PH service Providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

d. Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.

e. Procedures for training and consultation with each other to facilitate continuity of care and cost-effective use of resources.

f. A mechanism for timely resolution of any clinical and fiscal payment disputes; including procedures for entering into binding arbitration to obtain final resolution.

g. Procedures for serving on Interagency Teams, as necessary.

h. Procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the Primary Contractor service managers and/or service Provider(s) and the PCP for Members with special health needs (e.g. children and adolescents in medical foster care and members with coexisting physical and behavioral health disorders such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and a serious mental illness, including persons diagnosed with ASD).

i. Provision of behavioral health crisis intervention and other necessary In-Plan Services to Members with behavioral health Emergency Medical Conditions. The PHSS is responsible for payment of all emergency and medically necessary non-emergency ambulance services. The PHSS and Primary Contractor must establish clear procedures for coordinating the transport and treatment of persons with behavioral health Emergency Medical Conditions who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities.

j. Procedures for the coordination of laboratory services.

k. Mechanisms and procedures to ensure coordination between the Primary Contractor service managers, Member services staff and Provider network with the PHSS.

l. Procedures for the PHSS to provide physical examinations required for the delivery of Behavioral Health Services, within designated timeframes for each service.

m. Procedures for the interaction and coordination of pharmacy services to include acknowledgment that:

   i) All pharmacy services are the payment responsibility of the Member's PHSS. All prescribed medications are to be dispensed through PHSS network pharmacies. This includes drugs prescribed by both the PHSS and the Primary Contractor Providers. The only exception is that the Primary Contractor is responsible for the payment of methadone when used in the
treatment of substance abuse disorders and when prescribed and dispensed by Primary Contractor service Providers;

ii) Neither the PHSS nor the Primary Contractor is billed for medications administered during the course of an inpatient stay. Inpatient psychiatric rates include the cost of all pharmaceuticals. Hospital inpatient rates are calculated to include ancillary costs, which are included in the per diem. Medications dispensed on an inpatient unit are an ancillary cost.

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

a) the drug is not being prescribed for the treatment of substance abuse/dependency/addiction or mental illness or to treat the side effects of psychopharmacological agents. Those drugs are to be prescribed by the PCP or specialists in the Member's physical care health network;
b) the prescribed drug does not conform to standard rules of the pharmacy services plan; e.g., use of generic or cost effective alternative(s), purchases from certain pharmacies, and quantity limited to a 30 day supply;
c) the drug is prescribed by a behavioral health Provider identified as not having a signed Provider Agreement with the Primary Contractor; or
d) the prescription has been identified as an instance of fraud, abuse, gross overuse, or is contraindicated because of potential interaction with other medications.

n) Procedures for monitoring behavioral health pharmacy services provided by the PHSS;
o) Procedures for notifying each other of all prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records;
p) Procedures for the timely resolution of any disputes which arise from the payment for or use of pharmaceuticals (e.g., use of anticonvulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when resolution between the PHSS and Primary Contractor does not occur;
q) Procedures for sharing independently developed quality management/Utilization Management information related to pharmacy services, as applicable;
r) Policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations [Section 4401(g) of OBRA 1990, Section 4.26, guidelines 1927(g), 42 CFR 456]; and

s) Procedures for the Primary Contractor to collaborate with the PHSS in identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs. Areas for particular attention include potential and actual adverse drug reactions; therapeutic appropriateness; under and over drug use; appropriate use of generic products; therapeutic duplication; drug/disease contraindications; drug to drug interactions; incorrect drug dosage or duration of treatment; drug allergy reactions; and clinical abuse/misuse.

t) A method for the Primary Contractor is required to provide the PHSS, upon its request, with a listing of the physicians in its initial Provider network and, on a quarterly basis, changes including terminations and additions.

2) The Primary Contractor must ensure through its Provider Agreements that its Providers interact and coordinate services with the PHSS and their PCPs.

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

a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.

b. Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.

c. Provide health records to each other, as requested.

d. Comply with the agreement between the Primary Contractor and the PHSS to assure coordination between behavioral and physical health care including resolution of any clinical dispute.

e. Be available to each other for consultation.

3) The Primary Contractor must establish procedures, which include referrals and interagency service planning, to coordinate In-Plan Service delivery with services delivered outside the scope of services covered by the Primary Contractor:

a. Supplemental Services

In addition to the In-Plan mental health, drug and alcohol and behavioral services listed in IV-4 A.1), supplemental mental health and drug and alcohol services may be made available to Members when the Primary Contractor determines the service to be clinically appropriate.
Supplemental Services are MA eligible services which are not part of the capitated, In-Plan benefit package (e.g. partial hospitalization for drug and alcohol abuse or dependence, targeted D&A case management, psychiatric rehabilitation services and community residential rehabilitation services). The Primary Contractor may, however, choose to purchase such services, in lieu of or in addition to an In-Plan Service.

b. Medical Care

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

i) privately-operated intermediate care facilities for persons with mental retardation (ICF/MR), and intermediate care facilities for persons with other related conditions (ICF/ORC);

ii) mental health residential treatment facilities;

iii) acute and extended acute psychiatric inpatient facilities;

iv) non-hospital residential detoxification, rehabilitation and halfway house services for drug/alcohol abuse or dependence; and

v) juvenile detention facilities for up to 35 days.

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

All emergency and non-emergency medically necessary ambulance transportation for both physical and Behavioral Health Services is the responsibility of the Member’s PHSS even when the diagnosis is provided by the BH-MCO.
c. Public Psychiatric Hospitalization

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

d. Emergency Services: Coverage and Payment

The Primary Contractor may not deny payment for Emergency Services obtained when a representative of the entity instructs the Member to seek Emergency Services.

The Primary Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

The Primary Contractor may not refuse to cover Emergency Services based on the emergency room Provider, hospital or fiscal agent not notifying the Member’s BH-MCO of the Member’s screening and treatment within ten (10) calendar days of presentation for Emergency Services.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Responsibility for inpatient admission will be based upon the Member’s Primary Diagnosis.

The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and the determination is binding on the Primary Contractor.

4) The Primary Contractor must enter into a written agreement with the CCYA to include, at a minimum:

a. Procedures for referral, authorization and coordination of care, including overall requirements for Children and Adolescents in Substitute Care and specific requirements for referral, review of Medical Necessity prior to admission to and coordination of care following discharge from accredited and non-accredited RTF services, and D&A non-hospital residential rehabilitation and detox programs.

b. Liaison relationships for individual cases and administration.

c. Release of records and BH-MCO representation in court.
d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.

e. Procedures to communicate denials of service by the Primary Contractor.

f. Provision of BH-MCO Provider directories, including electronic transmission where children and youth agency capacities exist

5) For children and adolescents who are served by multiple child serving systems, the Primary Contractor must:

a. Have well publicized written policies and procedures explaining the Primary Contractor is available to attend or convene Interagency Team meetings, at the request of or with the consent of the Parent or custodian.

b. Treat as a formal request for service a prescriber's request for services pursuant to an Interagency Team recommendation, with the deadlines and Complaint, Grievance and DPW Fair Hearing rights outlined in Appendix H.

c. At the Parent/custodian's or agency's request, serve on an Interagency Team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.

d. Coordinate specialized treatment plans for children and adolescents with special health needs, including early intervention.

6) The Primary Contractor is required to coordinate service planning and delivery with human services agencies. The Primary Contractor is required to have a letter of agreement with:

a. Area Agency on Aging.

b. County Juvenile Probation Office (including the same components as the agreement with the CCYA in IV-4.B.4)).

c. County Drug and Alcohol Agency, including:

   i) A description of the role and responsibilities of the SCA.

   ii) Procedures for coordination with the SCA for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.

d. County offices of MH and MR, including coordination with the Health Care Quality Unit (HCQU).

e. Each school district in the county.

f. County MH/MR Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.

g. Early intervention including:

   i) Infant-toddler early intervention (0-3 years) administered by the County MR office.

   ii) Pre-school intervention (3-5 years) administered by the local MAWA (mutually agreed upon written arrangement). The MAWA is most typically the Intermediate Unit.
7) The Primary Contractor must have in place written agreements with the other Primary Contractors in the Commonwealth to ensure continuity of care for Members who relocate from one HC zone to another. The Primary Contractor must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC-BH-N/C zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.

C. Member Services/Member Rights

1) The Primary Contractor must comply with any applicable federal and state laws that pertain to Members’ rights and ensure that their staff take those rights into account when furnishing services to Members.

2) Member Orientation

a. In consultation with the Department, the Primary Contractor must develop and distribute culturally/disability sensitive materials to Members regarding program features, policies, and procedures.

b. The Primary Contractor must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.

c. The Primary Contractor must provide to Members, within five days of enrollment, the names, locations, telephone numbers of, and non-English languages spoken by, current network Providers in the Member’s service area, including identification of Providers that are not accepting new patients. In addition, the Primary Contractor must provide a list of current in-plan behavioral health network Providers to the Member upon the Member’s request. The Primary Contractor must make a good faith effort to give written notice of terminated contracts within 15 days after receipt or issuance of a termination notice, to each Member who receives primary care from or was seen on a regular basis by the terminated Provider.

d. The Primary Contractor must provide each Member with the name of one individual in the program to be the Member’s "point of contact" to explain plan services and assist the Member to access services.

e. The Primary Contractor must publish and distribute a Member handbook, upon approval by the Department and input from the counties served, to all Members within 5 days of enrollment and make it available to other interested parties, upon request. In addition, the Primary Contractor must notify all Members of their right to request and obtain information related to the Provider network, benefits, Member rights and protections, and Complaint, Grievance, and DPW Fair Hearing procedures at least once a year. The handbook must be printed at no higher than a fourth grade reading level, delineating a Member's rights and responsibilities, as well as covering the following information:
i) the amount, duration and scope of In-Plan Services and an explanation of any service limitations or exclusions;

ii) a specific statement that provides: “this managed care plan may not cover all your health care expenses. Read your contract (handbook) carefully to determine which health care services are covered;”

iii) how to contact Member Services and a description of its function;

iv) no co-pay or cost sharing obligation by the Member;

v) how to choose Providers within a level of care;

vi) how to obtain emergency transportation and non-emergency medically necessary transportation;

vii) the extent to which and how Members may obtain benefits from Out-of-Network Providers;

viii) the counseling or referral services the Primary Contractor does not cover because of moral or religious objections. The Primary Contractor must inform Members that the Department will furnish information on how and where to obtain the service;

ix) how to obtain services when a Member moves or visits out-of-county/out-of-state;

x) how to access Behavioral Health Services, including self-referral and Prior Authorized Services;

xi) confidentiality protections, including access to clinical records by oversight agencies and through the Quality Management/Utilization Management program;

xii) information concerning methods for coordinating services for Members;

xiii) how to obtain Medical Assistance Transportation Program (MATP) services;

xiv) phone numbers of the clinical sentinel and BH advocacy agencies;

xv) phone number of the Department’s Fraud and Abuse hotline;

xvi) information on “Advance Directives” (durable power of attorney and living wills), including the following:

a) written policies and procedures per State mandates and requirements;

b) the description of State law;

c) the process for notifying the Member of any changes in State law. The information must reflect changes in state law as soon as possible but no later than ninety (90) days after the effective date of the State law change;

d) any limitation the Primary Contractor has regarding implementation of advanced directives as a matter of conscience;
xvii) information to adult Members regarding Member rights.
xviii) explanation of the operation of the BH-MCO.
xix) explanation of how Members are assisted in making appointments and obtaining services including the explanation of procedures for accessing self-referred and Prior Authorized Services.
xx) explanation of how Members are assisted to obtain transportation through MATP.
xxi) explanation of how Member Complaints and Grievances are handled.
xxii) explanation of rights, which must include the following:
a) each Member will be treated with respect and with due consideration for his or her dignity and privacy;
b) each Member will receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand;
c) each Member will participate in decisions regarding his or her health care, including the right to refuse treatment unless the individual meets criteria for involuntary treatment under the MH/MR Act of 1966;
d) each Member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of seclusion and restraint;
e) each Member may request and receive a copy of his or her medical records and request that they be amended or corrected in accordance with the Federal Privacy Law;
f) each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Primary Contractor, Providers or any state agency treats the Member;
g) each Member has the right to request a second opinion from a qualified health care professional within the Provider network. The Primary Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.
xxiii) restrictions on the Member’s freedom of choice among Providers.
f. In addition to including the following information in the Member handbook, the Primary Contractor must provide each Member written notice of any Department-approved change in the following information at least 30 days before the intended date of the change:

i) Complaint, Grievance, and DPW Fair Hearing procedures and timeframes (as provided in Appendix H) that must include the following:

a) For DPW Fair Hearings.
   i. the right to a hearing.
   ii. the method for obtaining a hearing.
   iii. the rules that govern representation at the hearing.

b) The right to file Complaints and Grievances

c) The requirements and timeframes for filing a Complaint or Grievance by phone.

d) The availability of assistance in the filing process

e) The toll-free numbers that the Member can use to file a Grievance or an appeal by phone.

f) The fact that, when requested by the Member, benefits will continue if the Member files a Complaint (one of the five types of Complaints that allow for continuation of benefits, as specified in Appendix H), Grievance or request for DPW Fair Hearing within the timeframes specified for filing.

g) Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

ii) Instructions for obtaining care in an emergency, including:

a) locations of any emergency settings and other location at which Providers and hospitals furnish Emergency Services;

b) the use of the 911-telephone system or its local equivalent;

c) what constitutes an Emergency Medical Condition and Emergency Services;

d) the fact that Prior Authorization is not required for Emergency Services;

e) the fact that the Member has a right to use any hospital or other setting for Emergency Services.

3) The Primary Contractor must develop and implement programs for public education and prevention including behavioral health education materials and activities.

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

1) General Authority

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

2) Reasons for Disenrollment

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

a. Member’s loss of MA eligibility.
b. Placement of the Member in a nursing facility for more than 30 consecutive days.
c. Placement of the Member in any state facility, including a state psychiatric hospital.
d. Placement of the Member in a Juvenile Detention Center for more than 35 consecutive days.
e. Change in permanent residence of the Member which places the Member outside the BH-MCO’s service area.
f. Change in Member’s status to a recipient group which is exempt from the HC Program.
g. Determination by the Department that the Member is eligible for the Health Insurance Premium Payment Program (HIPP).
h. Member’s enrollment in the Pennsylvania Department of Aging (PDA) Waiver.
i. Member residing in PA Veterans Home, effective January 1, 2009, contingent upon approval from CMS of a State Plan Amendment (Please Note: The Primary Contractor will be notified when this change is approved by CMS).

3) The Primary Contractor shall not terminate any Member from the HC-BH Program.

4) A Member's termination from enrollment becomes effective on a date specified by the Department. The Primary Contractor must have policies and procedures to comply with any Department enrollment termination and for the Member's continuity of care as described in IV-4.B.7.

E. Complaint and Grievance System

1) General

The Primary Contractor must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress against the Primary Contractor. The Primary Contractor may not take any adverse action against a Provider for assisting a Member in the understanding of or filing of a Complaint or Grievance under the Member Complaint and Grievance System.
2) Member Complaint and Grievance System

The Primary Contractor must develop, implement, and maintain a Complaint and Grievance system which provides for settlement of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in Appendix H.

a. The Primary Contractor must provide Members and Parents/custodians of children and adolescents (for CISC, both Parents, if whereabouts are known and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DPW Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a Complaint or Grievance.

b. The Primary Contractor must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the Primary Contractor.

c. Denials of service or coverage must be in writing, notifying the Member or Parent/custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a Grievance and/or request a DPW Fair Hearing and the process for doing so.

d. The Primary Contractor must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.

e. The Primary Contractor must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.

f. The Primary Contractor Grievance system may not be a prerequisite to or replacement for the Member's right to request a Fair Hearing (in accordance with 42 CFR 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the Primary Contractor. The Primary Contractor must cooperate with and adhere to the Department’s procedures and decisions.

g. Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS's Office of Inspector General, and the United States Justice Department.
3) Denial of Services

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

The Primary Contractor may not deny or reduce the amount, duration, or scope of a required service solely because of a Member’s diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the Primary Contractor must have a process for expedited review of such Grievances to occur within 48 hours of the request.

Any time the Primary Contractor denies a request for authorization for service, the Primary Contractor must notify the Member or the Parent/custodian of a child or adolescent, in writing. The written notification must include:

a. Specific reasons for the denial with references to the program provisions;

b. A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.

c. A description of the Member’s right to file a Grievance and/or request a DPW Fair Hearing.

d. Information for the Member describing how to file a Grievance and/or request a DPW Fair Hearing.

e. An offer by the Primary Contractor to assist the Member in filing a Grievance and/or DPW Fair Hearing.

4) Provider Complaint System

The Primary Contractor must develop, implement and maintain a Provider Complaint system which provides for informal mediation and settlement of Provider Complaints at the lowest administrative level and a formal Complaint process when informal resolution is not possible.

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

The Department’s Bureau of Hearings and Appeals is not an appropriate forum and shall not be used by Providers to appeal decisions of the Primary Contractor.
II-5. **Requirements**

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

**A. General**

Participation will be limited to Primary Contractors who are BH-MCOs licensed by the Commonwealth as HMOs or as Risk Assuming PPOs with operating authority for the covered county/counties, or have made application for operating authority from the Departments of Health and Insurance. The Department will hold the Primary Contractors responsible for all financial risk. Financial risk arrangements must be clearly identified in all incorporating documents and intergovernmental agreements.

**B. Executive Management**

1) **Subcontractual Relationships and Delegation**

For each Subcontractor, the Primary Contractor and/or its BH-MCO must ensure that:

   a. The Subcontractor has been evaluated and determined competent to perform the activities to be delegated.

   b. The Subcontractor has been engaged via a written agreement between the Primary Contractor and/or its BH-MCO that specifies the activities and reporting responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor’s performance is inadequate.

   c. Performance monitoring will be conducted on an ongoing basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.

   d. Deficiencies or areas for improvement will be identified, and corrective action required.
3. The Primary Contractor is required to contract with existing Consumer/Family Satisfaction Teams in the counties served or establish such teams if they do not exist.

4. The Primary Contractor will be required to allocate a portion of Capitation funding for county government oversight functions.

5. The Primary Contractor is required to place all HealthChoices Capitation payments in a separate, restricted account(s).

6. The Primary Contractor is required to place Reinvestment Funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DPW with input from the counties served. Primary Contractors must have prior approval from DPW to carryover Reinvestment Funds from one Agreement year into a subsequent Agreement year; however, DPW approved reinvestment plan funds must continue to be tracked separately. Reinvestment Funds for DPW approved reinvestment plans can be retained for up to six (6) months after the time period delineated in the approved reinvestment plan, unless such date is otherwise extended by the Department. This includes reinvestment plans that cover more than one (1) year. After that time, unexpended Reinvestment Funds must be returned to the Department. Any funds remaining in the reinvestment account at the time of Agreement termination must be returned to DPW.

7. The Primary Contractor may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:
   
   a. A Chief Executive Officer with clear authority over the entire operation.
   
   b. A Medical Director who is a board certified psychiatrist licensed in the Commonwealth with at least five years combined experience in mental health and substance abuse services. The responsibilities of the Medical Director include:
      
      i) development of clinical practice standards, policies, procedures, and performance;
      
      ii) review and resolution of quality of care problems;
      
      iii) participation in Complaint and Grievance processes related to service denials and clinical practice;
      
      iv) development, implementation, and review of the internal Quality Management and Utilization Management programs;
      
      v) oversight of the referral process for specialty and Supplemental Services;
      
      vi) oversight and management of the behavioral health rehabilitation and residential services for children and adolescents;
      
      vii) leadership and direction in the clinical staff recruitment, credentialing, and privileging activities;
      
      viii) leadership and direction in the Prior Authorization and utilization review processes;
ix) leadership and direction of policies and procedures relating to confidentiality of clinical records; and
x) participation in any meetings called by the Department.

c. A Chief Financial Officer to oversee the budget and accounting system
d. Quality Management
e. Utilization Management
f. Management Information Systems
g. Prior Authorization to include:
i) assessment and substantiation of need for psychiatric and behavioral services provided by a Mental Health Professional;
ii) assessment and substantiation of need for drug and alcohol treatment services provided by a Drug and Alcohol Addictions Professional.
h. Member Services to communicate with Members, act as Member advocates, and coordinate Members' use of the Complaint and Grievance processes.
i. Provider Services to coordinate communications between the Primary Contractor and its Providers.

8) The Primary Contractor must organize and deliver services in accordance with principles established through the CASSP, the CSP; and BDAP's Principles of Effective Treatment and OMHSAS’ Cultural Competency Principles; see Appendices I, J, and CC respectively.

9) The Primary Contractor must have written agreements with the county mental health, mental retardation and drug and alcohol authorities assuring availability and access to In-Plan and Supplemental Services. Agreements must include provisions for the integration of crisis intervention services and the admission of any Member to a state mental hospital consistent with the established state mental hospital bed allocation assigned to the county as well as provisions for appropriate, coordinated response and dispute resolution processes related to court orders for behavioral health involuntary treatment services.

C. Administration

1) Administrative duties related to the daily operation of the program and interaction with Providers and Members such as those related to Member services, Provider services, Quality Management and Utilization Management, must be conducted in an administrative office in a location(s) approved by the Department.

2) The HealthChoices Program, along with the Enrollment Assistance Program, provides Members with information regarding the HC-BH-N/C program.
The Primary Contractor must have policies and procedures for the coordination with the EAP. The Primary Contractor must have informational materials; e.g., pamphlets and brochures, which can be used by the EAP to assist the Member’s access to BH Services. Any information materials developed for this program by the Primary Contractor must have the Department’s prior written approval. The Primary Contractor will be required to print and provide the EAP with an adequate supply of approved materials on a continued basis.

3) Training and Professional Development

The Primary Contractor must provide an ongoing process of training and professional development for Member services, Service Management, Quality Management and Utilization Management staff. Training topics should include but not be limited to: CSP and CASSP principles and BDAP treatment philosophy, Member rights, Complaint and Grievance process, Provider network access, human services, current clinical practice needs of special populations including persons with co-occurring mental health drug & alcohol conditions, persons with mental retardation, children in substitute care and/or in juvenile probation, persons diagnosed with ASD, school intervention services, and Medical Necessity criteria including the ASAM and PCPC.

4) The Primary Contractor must monitor the performance and quality of service of any BH Services Provider to which work is delegated to assure conformance with the terms of the Agreement.

5) The Primary Contractor must work in partnership with the designated county/municipal health department, and Primary Care Practitioner as applicable, to ensure that conditions identified in accordance with Chapter 25, Disease Prevention and Control Law (35 P.S. § 521.1 et seq.) are reported (e.g., tuberculosis, hepatitis).

6) Records Retention

a. General

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

The Primary Contractor and BH Services Providers also must agree to comply with all standards for record keeping specified by the Commonwealth. Operational data and medical record standards are described below, and complete standards are available in the HealthChoices Library.
The Primary Contractor and BH Services Providers must, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives, or federal agencies. Access shall be provided either on-site, during regular business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.

The Primary Contractor and BH Services Providers shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records, other than medical records, may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in their original form. Financial books, records, documents, and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives up to five years after the date of the last payment under the Agreement, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all work is completed.

b. Operational Data Reports

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

c. Clinical Records

The Primary Contractor must have written policies and procedures to maintain the confidentiality of and provide Member and other requesting entities access to the record, consistent with applicable state and federal confidentiality requirements. The Commonwealth must be afforded prompt access to all Members’ clinical records whether electronic or paper.

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

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to Members. Therefore, the Primary Contractor must have written standards for clinical record documentation which reflect legibility, accuracy, completeness, and that chronologically reflect the
evaluation, appropriateness of treatment, and Medical Necessity within the plan of care for the Member. A complete list of standards to follow are contained in 55 Pa. Code, Chapter 1101 general MA regulations and the HealthChoices clinical record components document located in the HealthChoices Library.

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

The Department is not required to obtain written approval from a Member before requesting the Member's clinical record from the Primary Contractor or any Provider, consistent with state and federal confidentiality requirements.

D. Provider Network/Relations

1) The Primary Contractor must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network, and cost effective alternative services, will be established with the input of the Department and the counties served. The Provider network must have the following features in place and documented:

   a. Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.
   b. Represent the cultural and ethnic diversity of Members and their neighborhoods.
   c. Clinical expertise and Cultural Competency in responding to Members with special needs.
   d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance abuse disorders among older adults (particularly those with co-existing medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons diagnosed with ASD, persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS.
   e. Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.
   f. Evidence of a cooperative relationship between the Primary Contractor and its Provider network, for example, inclusion of Providers by the Primary Contractor in the development of clinical protocols and Provider profiling.
The numbers of network Providers who are not accepting new Members.

The anticipated MA enrollment.

The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented.

The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.

The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The Primary Contractor must manage the Provider network through agreements which include the following provisions:

- Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.
- Criteria for Provider’s clinical privileges, as applicable.
- Clinical performance standards and data reporting requirements.
- Financial performance standards and data reporting requirements.
- Complaint procedures for Providers.
- Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.
- Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., mental retardation, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.
- Requirements for coordination, credentialing, and continuity of care with PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).
- Procedures for approving demonstration projects for In-Plan Service and treatment alternatives/innovations.
- Compliance with Act 33 (Child Protective Services Law 23 Pa. C. S. § 6301 et seq.) clearance for all individuals working with children and adolescents. Criminal background checks if required.
- Compliance with Act 13 (Older Protective Services Law), 35 P.S. 10225.101 et seq., background checks for working with older persons.
- Authorization of In-Plan Services in accordance with DPW approved Medical Necessity criteria and Prior Authorization procedures.
- Assurance that Providers delivering In-Plan Services to Members via a subcontractual arrangement with a network Provider meet the same requirements and standards as a network Provider.
n. Procedure to provide access to client records for quality of care and access reviews.

o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of Network)

3) The Primary Contractor must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The Primary Contractor must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

4) The Primary Contractor must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis. The Primary Contractor must make incident records and reports immediately available to the Department upon request.

5) The Primary Contractor must maintain procedures for immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OMAP, Bureau of Program Integrity.

6) The Primary Contractor must notify the Department promptly of any changes to the composition of its Provider network that affect the Primary Contractor's ability to make available all In-Plan Services or respond to the special needs of a Member or population group in a timely manner.

7) The Primary Contractor (PC)/BH-MCO shall develop a policy and procedure for considering Provider rate setting for review and approval by OMHSAS. The policy shall include the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies. The policy will include a statement that the PC/BH-MCO shall not institute an across the board rate decrease for all Providers or a specific Provider type or group of Providers unless the PC or its BH-MCO has: (i) notified the Department of its intention to impose such an across the board rate decrease at least forty-five (45) days prior to the imposition of such a rate decrease; (ii) provided the Department with the justification for instituting such an across the board rate decrease; (iii) discussed the proposed action with all affected Providers, and (iv) provided justification that such action will not adversely affect compliance with HealthChoices access and choice requirements.
8) The Primary Contractor must maintain a plan of orientation and ongoing training for network Providers. Training shall include but not be limited to:

CASSP and CSP principles and BDAP treatment philosophy; priority and Special Needs Population issues such as children in substitute care and/or juvenile probation; Prior Authorization of services; continuity of care; payment procedures; Complaint and Grievance rights and procedures; coordination requirements with PHSS and PCPs; coordination requirements with county behavioral health and human services systems; current clinical best practice and community service resources and advocacy organizations.

E. Provider Enrollment - Credentialing/Recredentialing

1) In maintaining the Provider network, the Primary Contractor must establish written credentialing and recredentialing policies and procedures. Primary Contractors must adhere to credentialing requirements under the Pennsylvania Department of Health regulations at 28 Pa. Code, Sections 9.761 and 9.762 for all In-Plan Services Provider types as well as for Providers of Supplemental Services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the Primary Contractor (who will ensure the service is within the Provider’s scope of practice) and approval from a county who wishes to offer the service. The Primary Contractor must submit a program description to OMHSAS for review. Upon approval of the service description, OMHSAS will determine the code that will be used in the HealthChoices Program only, and the Provider will report encounter data for this service under their existing Provider type designation. Credentialing policies and procedures must include, but not be limited to, the following criteria:

   a. Applicable license or certification as required by Pennsylvania law.
   b. Verification of enrollment in good standing with Medicaid (Providers of Supplemental Services must be enrolled in the MA program).
   c. Verification of an active MA Provider Agreement.
   d. Evidence of malpractice/liability insurance.
   e. Disclosure of any past or pending lawsuits/litigations.
   f. Board certification or eligibility, as applicable.
2) Except as provided by 42 CFR 438.12(b), the Primary Contractor may not discriminate for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Primary Contractor declines to include individual or groups or Providers in its network, it must give the affected Providers written notice of the reason for its decision.

3) The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

4) A Primary Contractor may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
   a. any information the Member needs in order to decide among all relevant treatment options.
   b. for the risk, benefit and consequences of treatment and non-treatment.
   c. for the Member’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.
   d. for Member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.

5) The Primary Contractor, or its Subcontractors may not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

6) The Primary Contractor shall have a process in place, approved by the Department, for consulting with the counties served regarding Providers to be enrolled in the network and those recredentialed.

F. Service Access

1) The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for Urgent situations, and within seven days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the Start Date and frequency of treatment services. Prior Authorization of emergency inpatient and emergency outpatient services is not permitted.

The Primary Contractor must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred Member within the access standard.
2) The Primary Contractor must maintain a Provider network which is geographi­cally accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the Member travels is at least two (2) Providers for each In-Plan Service:

a. Within 30 minutes travel time in Urban areas.
b. Within 60 minutes travel time in Rural areas.

The access standard for inpatient and residential services is at least two Providers for each In-Plan Service, one of which must be:

a. Within 30 minutes travel time in Urban areas.
b. Within 60 minutes travel time in Rural areas.

The access standard for in plan crisis intervention services (telephone and mobile) is a minimum of one Provider. The access standard for Drug and Alcohol Halfway House services is two Providers, regardless of gender segregation. That is, the Primary Contractor does not need to require two Providers each for halfway house services for both males and females.

Network Providers are not required to be located within the county covered by the Agreement. Adherence to the travel time requirements may be facilitated by the Primary Contractor's inclusion of out-of-county BH Services Providers in its network.

The Primary Contractor must obtain DPW approval for policies and procedures to cover situations in which the Primary Contractor determines that a Member is in need of a specialized In-Plan Service and a Provider is not available within the travel timeframes. The policy and procedures shall ensure the appropriate delivery of services and the availability of local supports for the Member.

3) The Primary Contractor must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process in accordance with Appendix T for admission, continued stay and discharge for all In-Plan Services. The Primary Contractor's service authorization system must include procedures for informing Providers and Members of authorization decisions.

4) The Primary Contractor must have written policies and procedures which comply with MA Bulletins 99-96-01 and 99-03-13 and Appendix V, to authorize care and transition Members to network Providers for Members who are in care at the time of the Agreement implementation. (Note: Bulletin 99-96-01 is specific to continuity of Prior Authorized Services for Members under age 21.) Policies and procedures must specifically address priority and Special Needs Populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers must also be included. Where disruption of services would have a significant negative impact on the Member, the Primary
Contractor must have provisions for the authorization and payment of services
delivered by Out-of-Network Providers. A transition monitoring plan must be
developed to ensure that procedures and protocols governing transition into
service are being followed and that transition problems are identified and cor­
rected. The transition plan should also address the Primary Contractor staff re­
cruitment and training prior to start-up and supervisory support during initial
implementation. Planning must also address network Provider credentialing,
contracting and training; the Primary Contract or telephone capacity related to
both Member services and Service Management functions; and MIS backup.

5) The Primary Contractor must have procedures for accessing Out-of-Network,
but In-Plan Services in emergency or unique situations including services for
Children and Adolescents in Substitute Care.

6) The Primary Contractor must have procedures to assure continuity of care for
Members affected by either Provider termination or loss of the Member’s MA
eligibility when Medical Necessity continues at the same or other level of care.

7) If 5% or more of the MA recipients in a County Assistance Office or a district
office within the county speak a language other than English as a first
language, the Primary Contractor must make available in that language all
information that is disseminated to English speaking Members. This
information includes, but is not limited to, Member handbooks, hard copy
Provider directories, education and outreach materials, marketing materials,
written notifications, etc. Interpreter services must be available, as practical
and necessary, by telephone and/or in person to ensure Members are able to
communicate with the Primary Contractor and Providers, and receive covered
benefits in a timely manner. The Primary Contractor must have policies and
procedures for ensuring language assistance services for people who have
limited proficiency in English.

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

8) The Primary Contractor is expected to refer any Member in need of any routine
and specialized medical and/or social service not provided by the Primary
Contractor to an appropriate agency/organization.
9) The Primary Contractor and its Provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa. C.S. Section 6311.

10) The Primary Contractor must assure that Members are provided reasonable access to Behavioral Health Services provided by Federally Qualified Health Clinics (FQHC), wherever FQHC Behavioral Health Services are available, within travel of 30 minutes (Urban) and 60 minutes (Rural).

11) In all agreements with health care professionals, the Primary Contractors must comply with the requirements specified in 42 CFR 438.214, which includes selection and retention of Providers, credentialing and recredentialing requirement and nondiscrimination.

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

1) General

The Primary Contractor must adhere to Department of Health Regulation 28 Pa. Code Chapter 9, Subchapter G. The Primary Contractor must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

a. Conform to state Medicaid plan QM requirements.
b. Assure a UM/QM committee meets on a regular basis.
c. Provide for regular UM/QM reporting to the Primary Contractor management and its Provider network (including profiling of Provider utilization patterns).
d. Provide opportunity for consumer (including representation for consumers in Special Needs Populations), persons in recovery, family (including Parents/custodians of children and adolescents) and county participation in program monitoring.

2) Utilization Management (UM)

The Primary Contractor must have Department approved written UM policies and procedures that include protocols for prior approval (in accordance with Appendix AA), determination of Medical Necessity, Concurrent Review, Denial of Services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of it’s UM function, the Primary Contractor must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of Behavioral Health Services, procedures, and use of facilities.
The Primary Contractor is required to have criteria and review procedures. Mental health review criteria must be compatible with guidelines provided in Appendix T. Drug and alcohol reviews must be conducted in accordance with the Pennsylvania Client Placement Criteria for adults issued by the Department of Health and for children and adolescents, with criteria compatible with those of the American Society of Addiction Medicine. The Primary Contractor will distribute the review and UM criteria to all Providers in its Provider network and to any new Provider who signs a Provider Agreement with the Primary Contractor. The Primary Contractor must also provide the criteria to Members, upon request.

3) Quality Management

a. The Primary Contractor agrees to implement a Quality Management Program that includes a Continuous Quality Improvement (CQI) process. The Primary Contractor agrees to fully comply with the Department’s Quality Management and Utilization Management standards. The Primary Contractor must provide that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects to be required by the Department in their contracts with the Primary Contractor and its Subcontractors must agree to cooperate fully in implementing these performance measures and projects.

b. Performance Improvement Projects

The Primary Contractor is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

The performance improvement projects must involve the following:

i) Measurement of performance using objective quality indicators.

ii) Implementation of system interventions to achieve improvement in quality.

iii) Evaluation and initiation of activities for increasing or sustaining improvement.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.
The Primary Contractor is required to report the status and results of each project to the Department, as requested.

The Primary Contractor must have a written Quality Management Plan that includes quality assessment and performance improvement processes designed to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. The continuous quality improvement process places emphasis on, but need not be limited to, high volume and high risk services and treatment and behavioral health rehabilitation services for children and adolescents.

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

4) Confidentiality

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

5) Member Satisfaction

The Primary Contractor or its Subcontractor must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (C/FST) (in accordance with Appendix L).

The Primary Contractor shall contract with existing consumer/family satisfaction teams, or establish such teams if they do not exist, to conduct satisfaction surveys for HC-BH Members. The Subcontract shall ensure technical support of the C/FST in report writing, conducting interviews and include funds for travel and staff development. The Department will approve the C/FST Subcontracts established.

An annual report must be submitted to the Department on the activities and findings of the consumer/family satisfaction teams and Member satisfaction survey. Members and their families, including Parents of children and adolescents who are seriously emotionally disturbed and/or who abuse substances, are to participate on the consumer/family satisfaction teams and in the design and
implementation of the survey process. Such participation is to include: serving on consumer/family satisfaction teams, the review of consumer/family satisfaction team and annual survey findings, and the determination of quality improvements to be undertaken based on the findings. The Primary Contractor should also have mechanisms which ensure that Member comments concerning Provider performance can be tracked in aggregate and be used as a component of Provider profiling. In addition, the Primary Contractor must cooperate in Member satisfaction assessments which may be performed by the Department, independent of the Primary Contractor’s internal process.

6) Provider Satisfaction

The Primary Contractor, either directly or via its Subcontractor, must have systems and procedures to assess Provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual Provider satisfaction survey. Areas of the survey must include claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management.

7) Department Review

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

8) Performance-Based Contracting

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

9) External Independent Assessment

On at least an annual basis, the Primary Contractor must provide necessary documentation in order to comply with independent external quality review organization (EQRO) activities. The review shall include:

a. Validation of the Primary Contractor’s quality improvement projects.
b. Validation of the Primary Contractor’s performance measures.

The Primary Contractor must provide, as necessary, a review of its compliance with state structural and operational standards. Information included in the EQRO must be derived from an assessment of compliance with standards that occurred within the last three years.

10) The Department will implemented a Pay for Performance program which provides for incentive payments in accordance with Appendix E.
II-6. PROGRAM OUTCOMES AND DELIVERABLES

A. Outcome Reporting

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the Primary Contractor must comply with the Department's program performance reporting requirements as delineated in Appendix K. The Primary Contractor must establish all coordination agreements and procedures necessary to collect the required data elements from the Providers, Members, etc.

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

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

B. Deliverables

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

1) Member Services
   Marketing materials; Member handbooks; educational materials; Complaint and Grievance policies and procedures; Prior Authorization and access policies and procedures; listing of Providers.

2) Administration
   Letters of agreement; Provider contracts/Subcontracts; Provider Complaint system procedures; Provider network; staff development plan; Provider directory; Provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral form; coordination agreements; Complaint and Grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and regulations.

3) Quality Management /Utilization Management
   QM plan; reports of QM activities; procedures for sharing independently developed QM/UM information related to pharmacy services; UM criteria and review procedures; clinical records and Member information; and corrective action plan(s).
4) Data  Descriptions of management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; Complaint and Grievance reports; performance outcome management reports, including the consumer registry and quarterly status; transition monitoring and monitoring reports.

5) Behavioral Health Rehabilitation Services for Children and Adolescents

Procedures for informing Members and Providers about services available concerning BHRS; procedures for evaluating Provider compliance with BHRS requirements; procedures for ensuring timely provision of services on an emergency or Urgent basis.

6) Other  Organization chart listing key staff/functions; management information system; management and financial data system; identification and location of service sites; plan for coordination with county mental health and drug and alcohol authorities, as applicable; coordination agreement including procedures for clinical dispute resolution between the PHSS and BH-MCO; DUR policies and procedures; incident reports and trend analyses.

II-7. FINANCIAL AND REPORTING REQUIREMENTS

A. Financial Standards

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

1) General

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

a. Risk Protection for High Cost Cases

The Department seeks to minimize risks that valid claims, submitted to BH-MCOs by Providers, for costs incurred by a recipient above a certain monetary threshold, might not be paid. For the first two Agreement periods, the Primary Contractor is not required to have this risk protection requirement in place. However, effective July 1, 2009, the Primary Contractor must have a risk protection arrangement in place until the Agreement expires. This risk protection arrangement must include individual stop loss reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one (1) Member during one (1) year in excess of $75,000. The Department may alter or waive the reinsurance requirement if the Primary Contractor submits an alternative risk protection arrangement that the Department determines is acceptable.

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

The Primary Contractor must submit its plan for risk protection for high cost cases 60 days prior to the beginning of each Agreement year. The Department will determine the acceptability of the reinsurance or alternate risk protection arrangement.

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

b. Equity Requirements

In addition to the Primary Contractor's responsibility to meet requirements of the ID, the Primary Contractor is required to meet and maintain minimum equity requirements for its Agreement throughout the life of the Agreement. The purpose of the standards is to assure payment of the Primary Contractor's obligations to Providers and to assure performance by the Primary Contractor of its obligations under the Agreement.
The Primary Contractor must provide documentation that it meets the minimum $1.5M SAP-based equity requirement. In addition, prior to completion of the Readiness Review, the Primary Contractor must provide its business plan to meet the equity requirements below during the first six quarters of the Agreement. Capitation revenues received from all Agreements held by a Primary Contractor will be summed when evaluating the necessary minimum equity amounts.

Each Primary Contractor must maintain minimum SAP-based equity equal to the greater of $1,500,000 or 5% of annual HealthChoices Capitation revenue net of the MCO Assessment obligations paid as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DPW to the Primary Contractor. The requirement may be phased in during the first six calendar quarters of the period. The following phase-in calculation, which will be reviewed for compliance every quarter during the first Agreement period, will be computed as follows:

End of 2nd Quarter:
The greater of [$1.5M] or [Average annual Capitation revenue net of MCO Assessment (derived by averaging the first 6 months and then annualizing) multiplied by 1%].

End of 3rd Quarter:
The greater of [$1.5M] or [Average annual Capitation revenue net of MCO Assessment (derived by averaging the first 9 months and then annualizing) multiplied by 2%].

End of 4th Quarter:
The greater of [$1.5M] or [Annual Capitation revenue net of MCO Assessment (derived by averaging the first 12 months and then annualizing) multiplied by 3%].

End of 5th Quarter:
The greater of [$1.5M] or [Annual Capitation revenue net of MCO Assessment (derived by averaging the first 15 months and then annualizing) multiplied by 4%].

End of 6th Quarter
The greater of [$1.5M] or [Annual Capitation revenue net of MCO Assessment (derived by averaging the first 18 months and then annualizing) multiplied by 5%].

The Primary Contractor's equity as of the last day of the most recent calendar quarter will be determined in accordance with SAP-based equity, as reported to ID, and compared to the minimum equity requirement amounts in order to determine compliance with this standard.
The Primary Contractor will be required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If equity is not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements of its Agreement.

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

- Discuss fiscal situation with Primary Contractor management;
- Require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
- Suspend enrollment of some or all recipients into the HC-BH Program.
- Terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

c. Insolvency Arrangement/Secondary Liability

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

i) insolvency insurance;

ii) an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DPW which is in place for the entire term of the Agreement;

iii) a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Proposer in the event of a default in payment resulting from bankruptcy or insolvency; or

iv) other arrangements, satisfactory to the Department, that are sufficient to ensure payment to Providers in the event of a default in payment resulting from bankruptcy or insolvency.

DPW reserves the right to discuss alternative insolvency protection arrangements before or during negotiations.
The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency.

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

The Primary Contractor must be in compliance with the insolvency arrangement provision prior to completion of the Readiness Review, during which final documents must be provided to DPW and verification of the arrangement will take place.

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

d. The Primary Contractor will maintain revenues paid by the Department under this Agreement in a contract-specific bank account or accounts. These accounts will not contain funds unrelated to this Agreement. The Primary Contractor may prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.

e. The Primary Contractor must maintain separate fiscal accountability for Medicaid funding under the Waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The Primary Contractor shall demonstrate satisfactorily during the Readiness Review that it has procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county, if the Primary Contractor has an Agreement in more than one HealthChoices county.

3) DPW’s obligation to make payments is limited to the Capitation payments provided by DPW’s Agreement. If DPW is obligated as a result of litigation to pay a Provider for a service rendered under this Agreement, the Primary Contractor will have an obligation to DPW in the same amount. DPW may offset an obligation it has to the Primary Contractor by this amount, or DPW may demand payment from the Primary Contractor.
4) Limitation of Liability

In accordance with 42 CFR 434.20, the Primary Contractor must assure that MA recipients will not be liable for the Primary Contractor debts if the Primary Contractor becomes insolvent.

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

5) Behavioral Health Service Cost Accruals

The Primary Contractor must have actuarial services available to provide rate and other support services needed under the Agreement. The contractor must provide DPW with an actuarial certification of liabilities at least annually. As part of its accounting and budgeting function, the BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The BH-MCO should reserve funds by major categories of service (e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the BH-MCO should conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary. The methodology will be reviewed during the Readiness Review, and a copy of the methodology must be provided to the Department.

6) Financial Performance

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

B. Acceptance of Department Capitation Payments

The Primary Contractor is capitated for all In-Plan Services. The obligation of the Department to make payments is limited to Capitation payments. The Department shall make Capitation payments to the Primary Contractor on a monthly basis in the following manner:

Subject to the two month delay described in Section I-4, on the first day of each month, the Department will identify Members, and for each Member whose enrollment is effective on the first of the month, as indicated on CIS, the Department shall make a PMPM payment as payment in full for any and all services provided to the Member that constitutes covered services. Payment will be released no later than the 15th day of the month; however, the Department, at its sole discretion, reserves the right to delay until July, all payments that would otherwise occur in June. For Member whose enrollment...
is effective any time after the first day of the month, Capitation will be prorated and paid at a later date.

- Appendix V, the HealthChoices Behavioral Health Recipient Coverage Document, provides for adjustments to the Department's obligation to make Capitation payments. Appendix V is subject to revision by the Department in its sole discretion and without the need to amend the Agreement.

- The Capitation payment will be equal to the amount awarded the Primary Contractor through the negotiation/cost evaluation process as outlined in II-4.B. Monthly Capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

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

The Department will recover Capitation payments made for the Members who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Members for up to eighteen (18) months after the service month for which payment was made. (See Appendix V, HealthChoices BH Recipient Coverage Document).

The Primary Contractor must agree to accept Capitation payments in this manner and must have written policies and procedures for receiving, reconciling and processing Capitation payments.
C. Physician Incentive Arrangements

The Primary Contractor may operate a physician incentive plan only in accordance with Federal requirements for physician incentive plans.

1) If the Primary Contractor is an HMO, the following requirements apply:

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

The HMO must disclose to the Department the information on Provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i) at the times indicated at 42 CFR 434.70(a)(3), in order to determine whether the incentive plan(s) meets the requirements of 42 CFR 417.479(d)-(g). As applicable, the HMO must provide the Capitation data required under paragraph (h) (1) (vi) for the previous calendar year to the Department by June 30 of each year. The HMO will provide the information on its physician incentive plans listed in 42 CFR 417.479(h) (3) to any Member, upon request.

2) If the Primary Contractor is a Prepaid Inpatient Health Plan (PIHP) or enters into a contract with a PIHP, the following requirements must be met:

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

D. Claims Payment and Processing

1) Payments to Providers

The Department believes that one of the advantages of a behavioral health managed care system is that it permits Primary Contractors to enter into creative payment arrangements intended to encourage and reward effective Utilization Management and quality of care. The Department therefore intends to give Primary Contractors as much freedom as possible to negotiate mutually acceptable payment rates. However, regardless of the specific arrangements made with Providers, the Primary Contractor must agree to make timely payments to both contracted and non-contracted Providers, subject to the conditions described below. The Primary Contractor must also agree to abide
by special reimbursement provisions for FQHCs described below.

The Primary Contractor agrees to negotiate and pay rates to FQHCs and Rural Health Clinics (RHCs) comparable to other Providers who provide comparable services in the Primary Contractor’s Provider network. The Primary Contractor cannot pay annual cost settlement or prospective payment. The Primary Contractor may require that an FQHC comply with Case Management procedures that apply to other entities that provide similar benefits or services.

The Primary Contractor shall not be obligated to pay Providers of authorized Behavioral Health Services unless bills for such services are submitted within one hundred and eighty (180) days from the date of service.

The Primary Contractor shall follow state law on invoicing requirements on uniform claims, including the CMS 1500 and UB92, and HIPAA regulations for electronic billing via the 837 I and 837 P.

2) The Primary Contractor shall adjudicate 90% of all Clean Claims within 30 days, 100% of Clean Claims within 45 days, and 100% of all claims within 90 days. The Primary Contractor shall provide the Department with a monthly report that supplies summary information on claims processed. This reporting requirement applies to claims processed by the Primary Contractor or its Subcontractor, as well as Capitation payments to Providers or Subcontractors of Behavioral Health Services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8), and are also available in the HealthChoices Library.

E. Retroactive Eligibility Period

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

F. Financial Responsibility for Dual Eligibles

The Primary Contractor must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the contracted Primary Contractor’s rate for the service for network Providers. The Primary Contractor and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. If the service is a covered Medicare service, the Primary Contractor is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the Primary Contractor’s Provider Network and whether or not the Medicare Provider has complied with the authorization requirements of the Contractor. Since Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating Providers, Medicare Providers seeking payment must be enrolled in Medicaid.
If no contracted BH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the Primary Contractor must pay deductibles and coinsurance up to the applicable Medical Assistance fee schedule amount for the service.

For Medicare services that are not covered by either MA or the Primary Contractor, the Primary Contractor must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the Primary Contractor do not exceed 80% of the Medicare-approved amount. In the event Medicare does not cover a service, the Primary Contractor may require Prior Authorization as a condition of payment for the service.

The Primary Contractor must ensure that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice, regardless of whether that Provider is enrolled in the Primary Contractor network. Primary Contractors may establish policies and procedures for their networks that maximize opportunities for consumers to have a choice of Medicare Providers.

G. Return of Funds

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

In the event that the Agreement with the Department ends and is not renewed, all funds available for shared reinvestment, except those in DPW approved reinvestment plans, or Reinvestment Funds in a plan submitted to DPW but which DPW has not taken a positive or negative action, must be returned to the Department within 14 months from the expiration of the Agreement.

H. In-Network Services

The Primary Contractor will be responsible for making timely payment for medically necessary, In-Plan Services.

1) In-Network Providers

The Primary Contractor will be responsible for making timely payment for medically necessary, In-Plan Services rendered by in-network Providers when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were rendered under the terms of the Primary Contractor’s contract with the Provider; or
d. Services were prior authorized.

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

2) Out-of-Network Providers

The Primary Contractor will be responsible for making timely payments to Out-of-Network Providers for medically necessary, In-Plan Services when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were prior authorized by the Primary Contractor; or

d. Medically necessary services were rendered during an emergency placement by the child welfare agency.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the Primary Contractor. The Primary Contractor must assure that Out-of-Network Providers coordinate with respect to payment. The Primary Contractor must assure that cost to Members is no greater than it would be if services were provided within the Provider network.

An Out-of-Network Provider, which is an enrolled MA Provider and which is billing the Primary Contractor for covered HealthChoices In-Plan Services, shall not balance bill the Member.

An Out-of-Network Provider, which is not an enrolled Medicaid Provider, may balance bill the Member if the Member chose to receive service from that particular Provider. However, if the Primary Contractor is referring a Member to an Out-of-Network Provider, the Primary Contractor must pay deductibles and co-insurance up to the applicable Medical Assistance fee schedule amount for the service. In these circumstances, the Member cannot be subject to balance billing by the Provider.

3) Liability During an Active Provider Complaint

The Primary Contractor will not be liable to pay claims to Providers if the validity of the claim is being challenged by the Primary Contractor through a Complaint process or appeal, unless the Primary Contractor is obligated to pay the claim or a portion of the claim through its contract with the Provider.
I. Third Party Liability (TPL)

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

1) Cost Avoidance Activities

a. The Primary Contractor has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. 1396a(a)(25) plans, and workers compensation. Except as provided in J.1) b., the Primary Contractor must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are available. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the appropriate HIPAA 837 Loop(s) for Medicare, and the Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided. The Primary Contractor shall not be held responsible for any TPL errors in the Department's Eligibility Verification System (EVS) or the Department's TPL file.

b. The Primary Contractor agrees to pay, and to require that its Subcontractors pay, all Clean Claims for EPSDT services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the Primary Contractor is notified by the Department of such support orders or to the extent they become aware of such orders, and then seek reimbursement from liable third parties. The Primary Contractor shall communicate and encourage Providers to bill other primary insurance first, prior to submitting the claim to Medicaid. The Primary Contractor recognizes that cost avoidance of these claims is prohibited.

c. The Primary Contractor may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The Primary Contractor may neither unreasonably delay payment nor deny payment of claims unless the probable existence of third party health-related insurance coverage is established at the time the claim is adjudicated.
2) Post-Payment Recoveries

a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) other resources. Health-related insurance coverage is ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The term “other resources” means all other resources and includes, but is not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all "other resources" as defined in paragraph 2) a. above. Any correspondence or inquiry forwarded to the Primary Contractor (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the consumer and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Primary Contractor may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident if the services are otherwise covered. Those funds recovered by the Commonwealth under the scope of these "other resources" shall be retained by the Commonwealth.

c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the Primary Contractor's untimely submission of notice of legal involvement where the Primary Contractor has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Primary Contractor. The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

d. The Primary Contractor has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of twelve (12) months from the date of payment. Notification of intent to pursue, collect and retain health-related claims not recovered by the Primary Contractor within the twelve (12) months from the date of payment will become the sole and exclusive right of the Department to pursue, collect and retain. The Primary Contractor is responsible to notify the Department of all cases recovered within the twelve (12) month period.
e. Should the Department lose recovery rights to any claim due to late or untimely filing of a claim with the liable third party, and the untimeliness in billing that specific claim is directly related to untimely submission of encounter data, additional records under special request, or inappropriate denial of claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable claim shall be assessed against the Primary Contractor.

f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this document can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of liability against the Primary Contractor.

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

3) Health Insurance Premium Payment (HIPP) Program

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

The Department shall not purchase Medigap policies for equally eligible Members in the HC-BH-N/C zone.

4) Requests for Additional Data

The Primary Contractor must provide, at the Department's request, such information not included in the encounter data submissions that may be necessary for the administration of TPL activity. The Primary Contractor shall use its best efforts to provide this information within fifteen (15) calendar days of the Department's request. There are certain Urgent requests involving cases for minors that require information within forty-eight (48) hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information shall be maintained as required by federal and state regulations.
5) Accessibility to TPL Data

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

6) Third Party Resource Identification

a. Third party resources identified by the Primary Contractor, which do not appear on the Department’s TPL database, must be supplied to the Department’s TPL Division by the Primary Contractor on at least a monthly basis. The method of reporting shall be via electronic or manual submission or by any alternative method approved by the Department. For electronic submissions, the Primary Contractor must follow the required report format, data elements, and tape specifications supplied by the Department. For manual submissions, the Primary Contractor must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department’s TPL Division will use these submissions for subsequent updates to the system.

b. The Primary Contractor shall use the Department’s verification systems (i.e. POSNET and EVS) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

7) Damage Liability

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

J. Estate Recovery

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

a. Public or private nursing facility services;

b. Residential care at home or in a community setting; or

c. Any hospital care and prescription drug services provided while receiving nursing facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.
K. Performance Management Information System and Reporting

1) General

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

To measure the Primary Contractor’s accomplishments in the areas of access to care, behavioral health outcomes, quality of life, and Member satisfaction, the Primary Contractor must provide the Department with uniform service utilization, Quality Management, and Member satisfaction/Complaint/Grievance data on a regular basis. The Primary Contractor also must cooperate with the Department in carrying out data validation steps. The Department intends to use this information as part of a collaborative effort with the Primary Contractors to effect continuous quality improvement.

This data will include components specified by the Department and also problem areas targeted by the continuous quality improvement program, both of which may change from time to time. The Primary Contractor will manage the program in compliance with the Department’s standards and requirements and will provide data reports to support this management.


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

2) Management Information System

The Department requires an automated management information system (MIS). There are numerous components required for the complete system. They are service authorization, Member Complaint and Grievance, Provider Complaint, Provider profiling, claims processing including TPL identification, Member enrollment, financial reporting, Utilization Management, encounter data, performance outcomes, Quality Management, and suspected/substantiated fraud and abuse. Of these components, service authorization, Provider...
profiling, claims processing (including TPL) encounter data and Member enrollment must be integrated.

The Primary Contractor's MIS must be compatible with the Department's Pennsylvania Open Systems Network (POSNet) and have FTP connection capability with DPW’s PROMISE contractor, EDS (Electronic Data Systems).

The Primary Contractor must comply with the policy and procedures governing the operation of the Department's Pennsylvania Open Systems Network (POSNet), as defined in the document titled ‘Business Partner Network Connectivity’ contained in the HealthChoices Library.

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

The Primary Contractor is required to maintain an automated Provider directory. Upon request, the Primary Contractor is required to provide this directory to the Department via POSNet or via CD-ROM.

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

3) Encounter and Alternative Payment Arrangements Data

The Department requires the Primary Contractor to submit a separate record, or "pseudo claim," each time a Member has an encounter with a Provider. This includes encounters with Providers which are reimbursed on a Fee-for-Service or Alternative Payment Arrangement basis. An encounter is a service provided to a Member. This would include, but not be limited to, a professional contact between a Member and a Provider and will result in more than one encounter if more than one service is rendered. For services provided by Primary Contractors and Subcontractors, it is the responsibility of the Primary Contractor to take appropriate action to provide the Department with accurate and complete encounter data. The Department's point of contact for encounter data will be the Primary Contractor and not other Subcontractors or Providers.

The Department requires the Primary Contractor to submit a separate Alternative Payment Arrangement record for each advance payment made to a contractor or Provider responsible for all or part of a Member's behavioral health care. If the payment is an Alternative Payment Arrangement reimbursement, a separate record is required to report the amount paid on behalf of each Member. It is the responsibility of the Primary Contractor to take appropriate action to provide the Department with accurate and complete data for payments made by the Primary Contractor to its contractors and Providers; the Department's point of contact for Alternative Payment Arrangement data will be the Primary Contractor and not other Subcontractors or Providers.
The Department will validate the accuracy of data on the 837 and Alternative Payment Arrangement data files. Validation criteria are included in the HIPAA Implementation Guides and PROMISe Companion Guides for the 837 transactions and the Alternative Payment Arrangement File Format and in the Aggregate Encounter and Complaint and Grievance Reporting Manuals. For the 837 transactions, the HIPAA Implementation Guides can be obtained (free of charge) at www.wpc-edi.com/hipaa/ and the PROMISe Companion Guides are available (free of charge) by contacting OMHSAS. The Alternative Payment Arrangement File Format and the Aggregate Encounter and Complaint and Grievance Reporting Manuals can be found in the HealthChoices Library.

a. 837 Transaction. The 837 Transaction must include, at a minimum, the data elements listed in the HIPAA Implementation Guides and PROMISe Companion Guides.

b. Aggregate Data. The aggregate data submittal must include, at a minimum, the data elements/reports listed in the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

c. Data Format. The Primary Contractor must agree to submit Encounter and Alternative Payment Arrangement data electronically to the Department through PROMISe using the FTP. Data file content must conform to the requirements specified in the HIPAA Implementation Guides and PROMISe Companion Guides and the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

d. Timing of Data Submittal.

An encounter must be submitted and pass PROMISe edits on or before the last calendar day of the third month after the Primary Contractor paid/adjudicated the encounter.

Acceptable Alternative Payment Arrangement (formerly known as subcapitation) data must be submitted and found acceptable to the Department within thirty (30) days after the period or case for which the payment applies.

The Primary Contractor must adhere to the file size specifications provided by the Department. A file submission schedule will be developed and provided to the Primary Contractor.
e. Member Medical Information

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

f. Data Validation

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

L. Audits

All costs incurred under the Agreement are subject to audit by the Department or its designee for final approval and acceptability, in accordance with industry standards, applicable accounting principles, and Federal and State regulations and policy. Additional information on auditing is contained in Appendix W and the HealthChoices Financial Reporting Requirements, (Appendix P), also available in the HealthChoices Library. The Primary Contractor is responsible to comply with audit requirements as specified in the HealthChoices Audit Clause (Appendix W).

M. Restitution

The Primary Contractor shall make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due to the Primary Contractor under this Agreement whether such overpayment is discovered by the Primary Contractor, the Department, or other third party.

N. Claims Processing and Management Information System (MIS)

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

. The Membership management system must have the capability to receive, update and maintain the Primary Contractor’s Membership files consistent with information provided by the Department.

. The claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this document. Claims history must be maintained with sufficient detail to meet all Department reporting and encounter requirements.
The Provider management system must have the capability to store information on each Provider sufficient to meet the Department's reporting requirements.

The Primary Contractor must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.

The Primary Contractor must have the capability to electronically transfer data files with the Department.

The Primary Contractor must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification Rule for the eight electronic transactions and for the code sets used in these transactions.

Primary Contractor must have a procedure for maintaining recipient enrollment and eligibility data. Include a procedure for reconciliation of data discrepancies between their eligibility database and the Department’s EVS, CIS and daily monthly eligibility file transfers.

The Primary Contractor's information system shall be subject to review and approval by the Department at any time.

O. Data Support

The Department will make files available to the Primary Contractor on a routine basis that will allow them to effectively meet their obligation to provide services and record information consistent with Agreement requirements (See Appendix O). The Department expects to provide daily and monthly 834 files, 820 and MCO payment summary files, List of Active and Closed Providers File, ARM 568 File, Quarterly Network Provider File, Procedure Code and Diagnosis Code Files.

P. Federalizing General Assistance (GA) Data Reporting

The Primary Contractor must submit a properly formatted monthly file to the Department regarding payments applicable to state-only general assistance (GA) Members. The file shall include data on hospital claims paid by the Primary Contractor during the reporting month. The files shall include data for three (3) types of hospital services as listed below:

- Admissions to inpatient psychiatric hospitals
- Admissions to acute care hospitals
- Admissions to rehabilitation hospitals
The following types of information must be included in each record on the file:

- HMO code
- Provider
- Member
- Claim
- Additional data elements as required by Report #16 and Appendix P in the FRR.

Failure to comply with these requirements shall result in a penalty equal to three (3) times the amount that applies to other reporting requirements.
CONTRACTOR INTEGRITY PROVISIONS

1. Definitions.
   a. Confidential information means information that is not public knowledge, or available to the public on request, disclosure of which would give an unfair, unethical, or illegal advantage to another desiring to contract with the Commonwealth.
   b. Consent means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by pre-qualification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of execution of this agreement.
   c. Contractor means the individual or entity that has entered into this agreement with the Commonwealth, including directors, officers, partners, managers, key employees, and owners of more than a five percent interest.
   d. Financial Interest means:
      (1) Ownership of more than a five percent interest in any business; or
      (2) holding a position as an officer, director, trustee, partner, employee, or the like, or holding any position of management.
   e. Gratuity means any payment of more than nominal monetary value in the form of cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind.

2. The contractor shall maintain the highest standards of integrity in the performance of this agreement and shall take no action in violation of state or federal laws, regulations, or other requirements that govern contracting with the Commonwealth.

3. The contractor shall not disclose to others any confidential information gained by virtue of this agreement.

4. The contractor shall not, in connection with this or any other agreement with the Commonwealth, directly or indirectly, offer, confer or agree to confer any pecuniary benefit on anyone as consideration for the decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty by any officer or employee of the Commonwealth.
5. The contractor shall not, in connection with this or any other agreement with the Commonwealth, directly or indirectly, offer, give, or agree or promise to give to anyone any gratuity for the benefit of or at the direction or request of any officer or employee of the Commonwealth.

6. Except with the consent of the Commonwealth, neither the contractor nor anyone in privity with him or her shall accept or agree to accept from, or give or agree to give to, any person, any gratuity from any person in connection with the performance of work under this agreement except as provided therein.

7. Except with the consent of the Commonwealth, the contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material on this project.

8. The contractor, upon being informed that any violation of these provisions has occurred or may occur, shall immediately notify the Commonwealth in writing.

9. The contractor, by execution of this agreement and by the submission of any bills or invoices for payment pursuant thereto, certifies and represents that he or she has not violated any of these provisions.

10. The contractor, upon the inquiry or request of the Inspector General of the Commonwealth or any of that official's agents or representatives, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Inspector General to the contractor's integrity or responsibility, as those terms are defined by the Commonwealth's statutes, regulations, or management directives. Such information may include, but shall not be limited to, the contractor's business or financial records, documents or files of any type or form which refer to or concern this agreement. Such information shall be retained by the contractor for a period of three years beyond the termination of the contract unless otherwise provided by law.

11. For violation of any of the above provisions, the Commonwealth may terminate this and any other agreement with the contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these provisions, claim damages for all expenses incurred in obtaining another contractor to complete performance hereunder, and debar and suspend the contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or nonuse of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.
STANDARD CONTRACT
TERMS AND CONDITIONS - SAP

If an award is made to a Bidder, the Bidder shall receive a Contract that obligates Bidder to furnish the awarded item(s) in accordance with these Standard Contract Terms and Conditions - SAP:

1. TERM OF CONTRACT

The term of the Contract shall commence on the Effective Date (as defined below) and shall end on the Expiration Date identified in the Contract, subject to the other provisions of the Contract.

The Effective Date shall be: a) the date the Contract has been fully executed by the Contractor and by the Commonwealth and all approvals required by Commonwealth contracting procedures have been obtained or b) the date referenced in the Contract, whichever is later. The Contract shall not be a legally binding contract until after the fully-executed Contract has been sent to the Contractor.

The fully executed Contract shall not contain "ink" signatures by the Commonwealth. The Contractor understands and agrees that the receipt of an electronically-printed Contract with the printed name of the Commonwealth purchasing agent constitutes a valid, binding contract with the Commonwealth. The printed name of the purchasing agent on the Contract represents the signature of that individual who is authorized to bind the Commonwealth to the obligations contained in the Contract. The printed name also represents that all approvals required by Commonwealth contracting procedures have been obtained.

The Contractor shall not start performance until all of the following have occurred: a. the Effective Date has arrived; b. the Contractor has received a copy of the fully-executed Contract; and c. the Contractor has received a Purchase Order. The Commonwealth shall not be liable to pay the Contractor for any supply furnished or work performed or expenses incurred before the Effective Date or before the Contractor receives a copy of the fully-executed Contract or before the Contractor has received a Purchase Order. Except as otherwise provided in Paragraph 3, no Commonwealth employee has the authority to verbally direct the commencement of any work or delivery of any supply under this Contract prior to the Effective Date.

2. PURCHASE ORDERS

The Commonwealth may issue Purchase Orders against the Contract. These orders constitute the Contractor's authority to make delivery. All Purchase Orders received by the Contractor up to and including the expiration date of the Contract are acceptable and must be performed in accordance with the Contract. Contractors are not permitted to accept Purchase Orders which require performance extended beyond those performance time periods specified in the Contract but in no event longer than ninety (90) days after the expiration date of the Contract period. Each Purchase Order will be deemed to incorporate the terms and conditions set forth in the Contract.

Purchase Orders will not include an "ink" signature by the Commonwealth. The electronically-printed name of the purchaser represents the signature of that individual who has the authority, on behalf of the Commonwealth, to authorize the Contractor to proceed.

Purchase Orders may be issued electronically or through facsimile equipment. The electronic transmission of a purchase order shall require acknowledgement of receipt of the transmission by the Contractor. Receipt of the electronic or facsimile transmission of the Purchase Order shall constitute receipt of an order. Orders received by the Contractor after 4:00 p.m. will be considered received the following business day.

The Commonwealth and the Contractor specifically agree as follows:

a. No handwritten signature shall be required in order for the Contract or Purchase Order to be legally enforceable.

b. Upon receipt of a Purchase Order, the Contractor shall promptly and properly transmit an acknowledgement in return. Any order which is issued electronically shall not give rise to any obligation to deliver on the part of the Contractor, or any obligation to receive and pay for delivered products on the part of the Commonwealth, unless and until the Commonwealth transmitting the order has properly received an acknowledgement.
c. The parties agree that no writing shall be required in order to make the order legally binding, notwithstanding contrary requirements in any law. The parties hereby agree not to contest the validity or enforceability of a genuine Purchase Order or acknowledgement issued electronically under the provisions of a statute of frauds or any other applicable law relating to whether certain agreements be in writing and signed by the party bound thereby. Any genuine Purchase Order or acknowledgement issued electronically, if introduced as evidence on paper in any judicial, arbitration, mediation, or administrative proceedings, will be admissible as between the parties to the same extent and under the same conditions as other business records originated and maintained in documentary form. Neither party shall contest the admissibility of copies of genuine Purchase Orders or acknowledgements under either the business records exception to the hearsay rule or the best evidence rule on the basis that the order or acknowledgement were not in writing or signed by the parties. A purchase order or acknowledgment shall be deemed to be genuine for all purposes if it is transmitted to the location designated for such documents.

d. Each party will immediately take steps to verify any document that appears to be obviously garbled in transmission or improperly formatted to include re-transmission of any such document if necessary.

Purchase Orders under three thousand dollars ($3,000) in total amount may also be made in person or by telephone using a Commonwealth Procurement VISA Card. When an order is placed by telephone, the Commonwealth agency shall provide the agency name, employee name, credit card number, and expiration date of the card. Contractors agree to accept payment through the use of the Commonwealth Procurement VISA card.

The Commonwealth reserves the right, upon notice to the Contractor, to extend the term of the Contract for up to three (3) months upon the same terms and conditions. This will be utilized to prevent a lapse in Contract coverage and only for the time necessary, up to three (3) months, to enter into a new contract.

3. INDEPENDENT CONTRACTOR

In performing its obligations under the Contract, the Contractor will act as an independent contractor and not as an employee or agent of the Commonwealth.

4. COMPLIANCE WITH LAW

The Contractor shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of the Contract.

5. ENVIRONMENTAL PROVISIONS

In the performance of the Contract, the Contractor shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations.

6. POST-CONSUMER RECYCLED CONTENT

Except as specifically waived by the Department of General Services in writing, any products which are provided to the Commonwealth as a part of the performance of the Contract must meet the minimum percentage levels for total recycled content as specified in Exhibits A-1 through A-8 to these Standard Contract Terms and Conditions - SAP.

7. COMPENSATION

a. The Contractor shall be required to perform at the price(s) quoted in the Contract. All items shall be performed within the time period(s) specified in the Contract. The Contractor shall be compensated only for items supplied and performed to the satisfaction of the Commonwealth. The Contractor shall not be allowed or paid travel or per diem expenses except as specifically set forth in the Contract.

b. Unless the Contractor has been authorized by the Commonwealth for Evaluated Receipt Settlement or Vendor Self-Invoicing, the Contractor shall send an invoice itemized by purchase order line item to the address referenced on the Purchase Order promptly after
items are satisfactorily delivered. The invoice should include only amounts due under the Contract/Purchase Order. The Purchase Order number must be included on all invoices. In addition, the Commonwealth shall have the right to require the Contractor to prepare and submit a "Work In Progress" sheet that contains, at a minimum, the tasks performed, number of hours, hourly rates, and the purchase order or task order to which it refers.

8. PAYMENT

a. The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. The required payment date is: (a) the date on which payment is due under the terms of the Contract; (b) thirty (30) days after a proper invoice actually is received at the "Bill To" address if a date on which payment is due is not specified in the Contract (a "proper" invoice is not received until the Commonwealth accepts the service as satisfactorily performed); or (c) the payment date specified on the invoice if later than the dates established by (a) and (b) above. Payment may be delayed if the payment amount on an invoice is not based upon the price(s) as stated in the Contract. If any payment is not made within fifteen (15) days after the required payment date, the Commonwealth may pay interest as determined by the Secretary of Budget in accordance with Act No. 266 of 1982 and regulations promulgated pursuant thereto. Payment should not be construed by the Contractor as acceptance of the service performed by the Contractor. The Commonwealth reserves the right to conduct further testing and inspection after payment, but within a reasonable time after performance, and to reject the service if such post payment testing or inspection discloses a defect or a failure to meet specifications. The Contractor agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the Contractor or its subsidiaries to the Commonwealth against any payments due the Contractor under any contract with the Commonwealth.

b. The Commonwealth shall have the option of using the Commonwealth purchasing card to make purchases under the Contract or Purchase Order. The Commonwealth's purchasing card is similar to a credit card in that there will be a small fee which the Contractor will be required to pay and the Contractor will receive payment directly from the card issuer rather than the Commonwealth. Any and all fees related to this type of payment are the responsibility of the Contractor. In no case will the Commonwealth allow increases in prices to offset credit card fees paid by the Contractor or any other charges incurred by the Contractor, unless specifically stated in the terms of the Contract or Purchase Order.

c. The Commonwealth will make contract payments through Automated Clearing House (ACH).

1) Within 10 days of award of the contract or purchase order, the contractor must submit or must have already submitted their ACH information within their user profile in the Commonwealth's procurement system (SRM).

2) The contractor must submit a unique invoice number with each invoice submitted. The unique invoice number will be listed on the Commonwealth of Pennsylvania’s ACH remittance advice to enable the contractor to properly apply the state agency’s payment to the invoice submitted.

3) It is the responsibility of the contractor to ensure that the ACH information contained in SRM is accurate and complete. Failure to maintain accurate and complete information may result in delays in payments.

9. TAXES

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction contractor from the payment of
any of these taxes or fees which are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction contract.

10. WARRANTY

The Contractor warrants that all items furnished and all services performed by the Contractor, its agents and subcontractors shall be free and clear of any defects in workmanship or materials. Unless otherwise stated in the Contract, all items are warranted for a period of one year following delivery by the Contractor and acceptance by the Commonwealth. The Contractor shall repair, replace or otherwise correct any problem with the delivered item. When an item is replaced, it shall be replaced with an item of equivalent or superior quality without any additional cost to the Commonwealth.

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Contractor warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to the Commonwealth under the contract. The Contractor shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of the Contract. This is upon condition that the Commonwealth provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the Contractor's written request, it shall be at the Contractor's expense, but the responsibility for such expense shall be only that within the Contractor's written authorization. The Contractor shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees, that the Contractor or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Contract. If any of the products provided by the Contractor in such suit or proceeding are held to constitute infringement and the use is enjoined, the Contractor shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If the Contractor is unable to do any of the preceding, the Contractor agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the Contractor under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Contractor without its written consent.

12. OWNERSHIP RIGHTS

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

13. ASSIGNMENT OF ANTITRUST CLAIMS

The Contractor and the Commonwealth recognize that in actual economic practice, overcharges by the Contractor's suppliers resulting from violations of state or federal antitrust laws are in fact borne by the Commonwealth. As part of the consideration for the award of the Contract, and intending to be legally bound, the Contractor assigns to the Commonwealth all right, title and interest in and to any claims the Contractor now has, or may acquire, under state or federal antitrust laws relating to the products and services which are the subject of this Contract.
14. HOLD HARMLESS PROVISION

The Contractor shall hold the Commonwealth harmless from and indemnify the Commonwealth against any and all claims, demands and actions based upon or arising out of any activities performed by the Contractor and its employees and agents under this Contract and shall, at the request of the Commonwealth, defend any and all actions brought against the Commonwealth based upon any such claims or demands.

15. AUDIT PROVISIONS

The Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Contractor to the extent that the books, documents and records relate to costs or pricing data for the Contract. The Contractor agrees to maintain records which will support the prices charged and costs incurred for the Contract. The Contractor shall preserve books, documents, and records that relate to costs or pricing data for the Contract for a period of three (3) years from date of final payment. The Contractor shall give full and free access to all records to the Commonwealth and/or their authorized representatives.

16. INSPECTION AND REJECTION

No item(s) received by the Commonwealth shall be deemed accepted until the Commonwealth has had a reasonable opportunity to inspect the item(s). Any item(s) which is discovered to be defective or fails to conform to the specifications may be rejected upon initial inspection or at any later time if the defects contained in the item(s) or the noncompliance with the specifications were not reasonably ascertainable upon the initial inspection. It shall thereupon become the duty of the Contractor to remove rejected item(s) from the premises without expense to the Commonwealth within fifteen (15) days after notification. Rejected item(s) left longer than fifteen (15) days will be regarded as abandoned, and the Commonwealth shall have the right to dispose of them as its own property and shall retain that portion of the proceeds of any sale which represents the Commonwealth’s costs and expenses in regard to the storage and sale of the item(s). Upon notice of rejection, the Contractor shall immediately replace all such rejected item(s) with others conforming to the specifications and which are not defective. If the Contractor fails, neglects or refuses to do so, the Commonwealth shall then have the right to procure a corresponding quantity of such item(s), and deduct from any monies due or that may thereafter become due to the Contractor, the difference between the price stated in the Contract and the cost thereof to the Commonwealth.

17. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 18, Force Majeure, and in addition to its other rights under the Contract, declare the Contractor in default by written notice thereof to the Contractor, and terminate (as provided in Paragraph 19, Termination Provisions) the whole or any part of this Contract or any Purchase Order for any of the following reasons:

   1) Failure to begin work within the time specified in the Contract or Purchase Order or as otherwise specified;
   2) Failure to perform the work with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Contract or Purchase Order terms;
   3) Unsatisfactory performance of the work;
   4) Failure to deliver the awarded item(s) within the time specified in the Contract or Purchase Order or as otherwise specified;
   5) Improper delivery;
   6) Failure to provide an item(s) which is in conformance with the specifications referenced in the Contract or Purchase Order;
   7) Delivery of a defective item;
   8) Failure or refusal to remove material, or remove and replace any work rejected as defective or unsatisfactory;
   9) Discontinuance of work without approval;
   10) Failure to resume work, which has been discontinued, within a reasonable time after notice to do so;
   11) Insolvency or bankruptcy;
   12) Assignment made for the benefit of creditors;
13) Failure or refusal within 10 days after written notice by the Contracting Officer, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;

14) Failure to protect, to repair, or to make good any damage or injury to property; or

15) Breach of any provision of the Contract.

b. In the event that the Commonwealth terminates this Contract or any Purchase Order in whole or in part as provided in Subparagraph a. above, the Commonwealth may procure, upon such terms and in such manner as it determines, items similar or identical to those so terminated, and the Contractor shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical items included within the terminated part of the Contract or Purchase Order.

c. If the Contract or a Purchase Order is terminated as provided in Subparagraph a. above, the Commonwealth, in addition to any other rights provided in this paragraph, may require the Contractor to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Issuing Office, such partially completed items, including, where applicable, reports, working papers and other documentation, as the Contractor has specifically produced or specifically acquired for the performance of such part of the Contract or Purchase Order as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Contract price. Except as provided below, payment for partially completed items including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the Contractor and Contracting Officer. The Commonwealth may withhold from amounts otherwise due the Contractor for such completed or partially completed works, such sum as the Contracting Officer determines to be necessary to protect the Commonwealth against loss.

d. The rights and remedies of the Commonwealth provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

e. The Commonwealth’s failure to exercise any rights or remedies provided in this paragraph shall not be construed to be a waiver by the Commonwealth of its rights and remedies in regard to the event of default or any succeeding event of default.

f. Following exhaustion of the Contractor’s administrative remedies as set forth in Paragraph 20, the Contractor’s exclusive remedy shall be to seek damages in the Board of Claims.

18. FORCE MAJEURE

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

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

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the Contractor, may suspend all or a portion of the Contract or Purchase Order.
19. **TERMINATION PROVISIONS**

The Commonwealth has the right to terminate this Contract or any Purchase Order for any of the following reasons. Termination shall be effective upon written notice to the Contractor.

a. **TERMINATION FOR CONVENIENCE**: The Commonwealth shall have the right to terminate the Contract or a Purchase Order for its convenience if the Commonwealth determines termination to be in its best interest. The Contractor shall be paid for work satisfactorily completed prior to the effective date of the termination, but in no event shall the Contractor be entitled to recover loss of profits.

b. **NON-APPROPRIATION**: The Commonwealth’s obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Contract or a Purchase Order. The Contractor shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under the Contract. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be paid for any appropriations available for that purpose.

c. **TERMINATION FOR CAUSE**: The Commonwealth shall have the right to terminate the Contract or a Purchase Order for Contractor default under Paragraph 17, Default, upon written notice to the Contractor. The Commonwealth shall also have the right, upon written notice to the Contractor, to terminate the Contract or a Purchase Order for other cause as specified in the Contract or by law. If it is later determined that the Commonwealth erred in terminating the Contract or a Purchase Order for cause, then, at the Commonwealth’s discretion, the Contract or Purchase Order shall be deemed to have been terminated for convenience under the Subparagraph 19.a.

20. **CONTRACT CONTROVERSIES**

a. In the event of a controversy or claim arising from the Contract, the Contractor must, within six months after the cause of action accrues, file a written claim with the contracting officer for a determination. The claim shall state all grounds upon which the Contractor asserts a controversy exists. If the Contractor fails to file a claim or files an untimely claim, the Contractor is deemed to have waived its right to assert a claim in any forum.

b. The contracting officer shall review timely-filed claims and issue a final determination, in writing, regarding the claim. The final determination shall be issued within 120 days of the receipt of the claim, unless extended by consent of the contracting officer and the Contractor. The contracting officer shall send his/her written determination to the Contractor. If the contracting officer fails to issue a final determination within the 120 days (unless extended by consent of the parties), the claim shall be deemed denied. The contracting officer’s determination shall be the final order of the purchasing agency.

c. Within fifteen (15) days of the mailing date of the determination denying a claim or within 135 days of filing a claim if, no extension is agreed to by the parties, whichever occurs first, the Contractor may file a statement of claim with the Commonwealth Board of Claims. Pending a final judicial resolution of a controversy or claim, the Contractor shall proceed diligently with the performance of the Contract in a manner consistent with the determination of the contracting officer and the Commonwealth shall compensate the Contractor pursuant to the terms of the Contract.

21. **ASSIGNABILITY AND SUBCONTRACTING**

a. Subject to the terms and conditions of this Paragraph 21, this Contract shall be binding upon the parties and their respective successors and assigns.

b. The Contractor shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of the
The Contractor may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of theContracting Officer, which consent may be withheld at the sole and absolute discretion of the Contracting Officer.

d. Notwithstanding the foregoing, the Contractor may, without the consent of the Contracting Officer, assign its rights to payment to be received under the Contract, provided that the Contractor provides written notice of such assignment to the Contracting Officer together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of this Contract.

e. For the purposes of this Contract, the term “assign” shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Contractor provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.

f. Any assignment consented to by the Contracting Officer shall be evidenced by a written assignment agreement executed by the Contractor and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of the Contract and to assume the duties, obligations, and responsibilities being assigned.

g. A change of name by the Contractor, following which the Contractor’s federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The Contractor shall give the Contracting Officer written notice of any such change of name.

22. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

During the term of the Contract, the Contractor agrees as follows:

a. In the hiring of any employees for the manufacture of supplies, performance of work, or any other activity required under the Contract or any subcontract, the Contractor, subcontractor or any person acting on behalf of the Contractor or subcontractor shall not by reason of gender, race, creed, or color discriminate against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.

b. Neither the Contractor nor any subcontractor nor any person on their behalf shall in any manner discriminate against or intimidate any employee involved in the manufacture of supplies, the performance of work or any other activity required under the Contract on account of gender, race, creed, or color.

c. The Contractor and any subcontractors shall establish and maintain a written sexual harassment policy and shall inform their employees of the policy. The policy must contain a notice that sexual harassment will not be tolerated and employees who practice it will be disciplined.

d. The Contractor shall not discriminate by reason of gender, race, creed, or color against any subcontractor or supplier who is qualified to perform the work to which the contract relates.

e. The Contractor and each subcontractor shall furnish all necessary employment documents and records to and permit access to its books, records, and accounts by the contracting officer and the Department of General Services’ Bureau of Contract Administration and Business Development for purposes of investigation to ascertain compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause. If the Contractor or any subcontractor does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the contracting officer or the Bureau of Contract Administration and Business Development.
f. The Contractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor.

g. The Commonwealth may cancel or terminate the Contract, and all money due or to become due under the Contract may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the agency may proceed with debarment or suspension and may place the Contractor in the Contractor Responsibility File.

23. CONTRACTOR INTEGRITY PROVISIONS

a. For purposes of this clause only, the words “confidential information,” “consent,” “contractor,” “financial interest,” and “gratuity” shall have the following definitions.

1) Confidential information means information that is not public knowledge, or available to the public on request, disclosure of which would give an unfair, unethical, or illegal advantage to another desiring to contract with the Commonwealth.

2) Consent means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of execution of this agreement.

3) Contractor means the individual or entity that has entered into the Contract with the Commonwealth, including directors, officers, partners, managers, key employees and owners of more than a five percent interest.

4) Financial interest means:

   a) Ownership of more than a five percent interest in any business; or
   
   b) Holding a position as an officer, director, trustee, partner, employee, or the like, or holding any position of management.

5) Gratuity means any payment of more than nominal monetary value in the form of cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind.

b. The Contractor shall maintain the highest standards of integrity in the performance of the Contract and shall take no action in violation of state or federal laws, regulations, or other requirements that govern contracting with the Commonwealth.

c. The Contractor shall not disclose to others any confidential information gained by virtue of the Contract.

d. The Contractor shall not, in connection with this or any other agreement with the Commonwealth, directly, or indirectly, offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for the decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty by any officer or employee of the Commonwealth.

e. The Contractor shall not, in connection with this or any other agreement with the Commonwealth, directly or indirectly, offer, give, or agree or promise to give to anyone any gratuity for the benefit of or at the direction or request of any officer or employee of the Commonwealth.

f. Except with the consent of the Commonwealth, neither the Contractor nor anyone in privity with him or her shall accept or agree to accept from, or give or agree to give to, any person, any gratuity from any person in connection with the performance of work under the Contract except as provided therein.
g. Except with the consent of the Commonwealth, the Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material on this project.

h. The Contractor, upon being informed that any violation of these provisions has occurred or may occur, shall immediately notify the Commonwealth in writing.

i. The Contractor, by execution of the Contract and by the submission of any bills or invoices for payment pursuant thereto, certifies, and represents that he or she has not violated any of these provisions.

j. The Contractor, upon the inquiry or request of the Inspector General of the Commonwealth or any of that official’s agents or representatives, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Inspector General to the Contractor’s integrity or responsibility, as those terms are defined by the Commonwealth’s statutes, regulations, or management directives. Such information may include, but shall not be limited to, the Contractor’s business or financial records, documents or files of any type or form which refers to or concern the Contract. Such information shall be retained by the Contractor for a period of three years beyond the termination of the Contract unless otherwise provided by law.

k. For violation of any of the above provisions, the Commonwealth may terminate this and any other agreement with the Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these provisions, claim damages for all expenses incurred in obtaining another Contractor to complete performance hereunder, and debar and suspend the Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or nonuse of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

24. CONTRACTOR RESPONSIBILITY PROVISIONS

a. The Contractor certifies, for itself and all its subcontractors, that as of the date of its execution of this Bid/Contract, that neither the Contractor, nor any subcontractors, nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the Contractor cannot so certify, then it agrees to submit, along with its Bid, a written explanation of why such certification cannot be made.

b. The Contractor also certifies, that as of the date of its execution of this Bid/Contract, it has no tax liabilities or other Commonwealth obligations.

c. The Contractor’s obligations pursuant to these provisions are ongoing from and after the effective date of the contract through the termination date thereof. Accordingly, the Contractor shall have an obligation to inform the Commonwealth if, at any time during the term of the Contract, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the Contractor to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default of the Contract with the Commonwealth.

e. The Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for investigations of the Contractor’s compliance with the terms of this or any other agreement between the Contractor and the Commonwealth, which results in the suspension or debarment of the Contractor. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor’s suspension or debarment.
f. The Contractor may obtain a current list of suspended and debarred Commonwealth contractors by either searching the internet at [http://www.dgs.state.pa.us/](http://www.dgs.state.pa.us/) or contacting the:

Department of General Services  
Office of Chief Counsel  
603 North Office Building  
Harrisburg, PA 17125  
Telephone No. (717) 783-6472  
FAX No. (717) 787-9138  

25. AMERICANS WITH DISABILITIES ACT  
a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the Contractor understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of the disability. As a condition of accepting this contract, the Contractor agrees to comply with the “General Prohibitions Against Discrimination,” 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through contracts with outside contractors.

b. The Contractor shall be responsible for and agrees to indemnify and hold harmless the Commonwealth of Pennsylvania from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the Contractor’s failure to comply with the provisions of subparagraph a above.

26. HAZARDOUS SUBSTANCES  
The Contractor shall provide information to the Commonwealth about the identity and hazards of hazardous substances supplied or used by the Contractor in the performance of the Contract. The Contractor must comply with Act 159 of October 5, 1984, known as the “Worker and Community Right to Know Act” (the “Act”) and the regulations promulgated pursuant thereto at 4 Pa. Code Section 301.1 et seq.

a. Labeling. The Contractor shall ensure that each individual product (as well as the carton, container or package in which the product is shipped) of any of the following substances (as defined by the Act and the regulations) supplied by the Contractor is clearly labeled, tagged or marked with the information listed in Paragraph (1) through (4):

1) Hazardous substances:
   a) The chemical name or common name,
   b) A hazard warning, and
   c) The name, address, and telephone number of the manufacturer.

2) Hazardous mixtures:
   a) The common name, but if none exists, then the trade name,
   b) The chemical or common name of special hazardous substances comprising .01% or more of the mixture,
   c) The chemical or common name of hazardous substances consisting 1.0% or more of the mixture,
   d) A hazard warning, and
   e) The name, address, and telephone number of the manufacturer.

3) Single chemicals:
a) The chemical name or the common name,
b) A hazard warning, if appropriate, and
c) The name, address, and telephone number of the manufacturer.

4) Chemical Mixtures:
a) The common name, but if none exists, then the trade name,
b) A hazard warning, if appropriate,
c) The name, address, and telephone number of the manufacturer, and
d) The chemical name or common name of either the top five substances by volume or those substances consisting of 5.0% or more of the mixture.

A common name or trade name may be used only if the use of the name more easily or readily identifies the true nature of the hazardous substance, hazardous mixture, single chemical, or mixture involved.

Container labels shall provide a warning as to the specific nature of the hazard arising from the substance in the container.

The hazard warning shall be given in conformity with one of the nationally recognized and accepted systems of providing warnings, and hazard warnings shall be consistent with one or more of the recognized systems throughout the workplace. Examples are:


Labels must be legible and prominently affixed to and displayed on the product and the carton, container, or package so that employees can easily identify the substance or mixture present therein.

b. Material Safety Data Sheet. The contractor shall provide Material Safety Data Sheets (MSDS) with the information required by the Act and the regulations for each hazardous substance or hazardous mixture. The Commonwealth must be provided an appropriate MSDS with the initial shipment and with the first shipment after an MSDS is updated or product changed. For any other chemical, the contractor shall provide an appropriate MSDS, if the manufacturer, importer, or supplier produces or possesses the MSDS. The contractor shall also notify the Commonwealth when a substance or mixture is subject to the provisions of the Act. Material Safety Data Sheets may be attached to the carton, container, or package mailed to the Commonwealth at the time of shipment.

27. COVENANT AGAINST CONTINGENT FEES

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

This Contract shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of laws provisions) and the decisions of the Pennsylvania courts. The Contractor consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania, waiving any claim or defense that such forum is not convenient or proper. The Contractor agrees that any such court shall have in personam jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

29. **INTEGRATION**

The RFQ - Invitation For Bids form, the Contract form, including all referenced documents, and any Purchase Order constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the Contractor has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Contract, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Contract. No modifications, alterations, changes, or waiver to the Contract or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties. All such amendments will be made using the appropriate Commonwealth form.

30. **CHANGES**

The Commonwealth reserves the right to make changes at any time during the term of the Contract or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Contract and actual quantities; 2) to make changes to the services within the scope of the Contract; 3) to notify the Contractor that the Commonwealth is exercising any Contract renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Contract to extend the completion date beyond the Expiration Date of the Contract or any renewals or extensions thereof. Any such change shall be made by the Contracting Officer by notifying the Contractor in writing. The change shall be effective as of the date of the change, unless the notification of change specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Contract, nor, if performance security is being furnished in conjunction with the Contract, release the security obligation. The Contractor agrees to provide the service in accordance with the change order. Any dispute by the Contractor in regard to the performance required by any notification of change shall be handled through Paragraph 19, “Contract Controversies”.
(A) **REQUIREMENT**

All construction products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Construction Products</th>
<th>Material</th>
<th>% of Post-consumer Materials</th>
<th>% of Total Recovered Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural Fiberboard</td>
<td>Recovered Materials</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Laminated Paperboard</td>
<td>Post-consumer Paper</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Rock Wool Insulation</td>
<td>Slag</td>
<td>-</td>
<td>75</td>
</tr>
<tr>
<td>Fiberglass Insulation</td>
<td>Glass Cullet</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Cellulose Insulation (loose-fill and spray-on)</td>
<td>Post-consumer Paper</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Perlite Composite Board Insulation</td>
<td>Post-consumer Paper</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Plastic Rigid Foam, Polyisocyanurate/Polyurethane: Rigid Foam Insulation</td>
<td>Recovered Material</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Foam-in-Place Insulation</td>
<td>Recovered Material</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Glass Fiber Reinforced Insulation</td>
<td>Recovered Material</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Phenolic Rigid Foam Insulation</td>
<td>Recovered Material</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Floor Tiles (heavy duty/commercial use)</td>
<td>Rubber</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Patio Blocks</td>
<td>Rubber or Rubber Blends</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Polyester Carpet Fiber Face</td>
<td>Polyethylene terephthalate (PET) resin</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Latex Paint:</td>
<td>Recovered Material</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>---Consolidated1</td>
<td>Recovered Material</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>---Reprocessed2</td>
<td>Recovered Material</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>-----White, Off-White, Pastel Colors</td>
<td>Recovered Material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----Grey, Brown, Earthtones, and Other Dark Colors</td>
<td>Recovered Material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower and Restroom Dividers/Partitions</td>
<td>Plastic</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Carpet Cushion:</td>
<td>Steel4</td>
<td>16</td>
<td>67</td>
</tr>
<tr>
<td>---Bonded Polyurethane</td>
<td>Old Carpet Cushion</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>---Jute</td>
<td>Burlap</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>---Synthetic Fibers</td>
<td>Carpet Fabrication Scrap</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>---Rubber</td>
<td>Tire Rubber</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Railroad Grade Crossing Surfaces</td>
<td>Coal Fly Ash</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>---Concrete</td>
<td>Tire Rubber</td>
<td>-</td>
<td>85</td>
</tr>
<tr>
<td>---Rubber</td>
<td>Steel</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>---Steel4</td>
<td>-</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>67</td>
<td>33</td>
</tr>
</tbody>
</table>

"Post-consumer" material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed its life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

"Recovered Materials“ refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

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1 Consolidated latex paint used for covering graffiti, where color and consistency of performance are not primary concerns.

2 Reprocessed latex paint used for interior and exterior architectural applications such as wallboard, ceiling, and trim; gutterboards; and concrete, stucco, masonry, wood, and metal surfaces.

3 The recommended recovered materials content for rubber railroad grade crossing surfaces are based on the weight of the raw materials, exclusive of any additives such as binders or additives.

4 The recommended recovered materials content levels for steel in this table reflect the fact that the designated items can be made from steel manufactured from either a Basic Oxygen Furnace (BOF) or an Electric Arc Furnace (EAF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel. Steel from the EAF process contains a total of 100% recovered steel, of which 67% is post-consumer.
(B) **BIDDER'S CERTIFICATION**

Bidder certifies that the construction product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE DELIVERED ITEM.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the construction product(s), to provide the Commonwealth with documentary evidence that the construction product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
EXHIBIT A-2
VEHICULAR PRODUCTS
RECYCLED CONTENT

(A) **REQUIREMENT**

All vehicular products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Vehicular Product</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-Refined Oil</td>
<td>25% re-refined oil base stock for engine lubricating oils, hydraulic fluids, and gear oils.</td>
</tr>
</tbody>
</table>

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed its life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

“Re-refined oil” is oil that is manufactured with a minimum of twenty-five percent basestock made from used oil that has been recovered and processed to make it reusable as oil. Once the oil has been refined, no difference can be detected between re-refined and virgin oil.

(B) **BIDDER’S CERTIFICATION**

Bidder certifies that the vehicular product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE REFERENCED ITEM.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the vehicular product(s), to provide the Commonwealth with documentary evidence that the vehicular product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
**EXHIBIT A-3**
**PAPER PRODUCTS**
**RECYCLED CONTENT**

(A) **REQUIREMENT**

All paper offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Item</th>
<th>Notes</th>
<th>Post-Consumer Content (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Printing and Writing Papers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reprographic</td>
<td>Business papers such as bond, electrostatic, copy, mimeo, duplicator and reproduction</td>
<td>30</td>
</tr>
<tr>
<td>Offset</td>
<td>Used for book publishing, commercial printing, direct mail, technical documents, and manuals</td>
<td>30</td>
</tr>
<tr>
<td>Tablet</td>
<td>Office paper such as note pads and notebooks</td>
<td>30</td>
</tr>
<tr>
<td>Forms bond</td>
<td>Bond type papers used for business forms such as continuous, cash register, sales book, unit sets, and computer printout, excluding carbonless</td>
<td>30</td>
</tr>
<tr>
<td>Envelope</td>
<td>Wove Kraft, white and colored (including manila) Kraft, unbleached Excludes custom envelopes</td>
<td>30</td>
</tr>
<tr>
<td>Cotton fiber</td>
<td>High-quality papers used for stationery, invitations, currency, ledgers, maps, and other specialty items</td>
<td>30</td>
</tr>
<tr>
<td>Text and cover</td>
<td>Premium papers used for cover stock, books, and stationery and matching envelopes</td>
<td>30</td>
</tr>
<tr>
<td>Supercalendered</td>
<td>Groundwood paper used for advertising and mail order inserts, catalogs, and some magazines</td>
<td>10</td>
</tr>
<tr>
<td>Machine finished groundwood</td>
<td>Groundwood paper used in magazines and catalogs</td>
<td>10</td>
</tr>
<tr>
<td>Papeteries</td>
<td>Used for invitations and greeting cards</td>
<td>30</td>
</tr>
<tr>
<td>Check safety</td>
<td>Used in the manufacture of commercial and government checks</td>
<td>10</td>
</tr>
<tr>
<td>Coated</td>
<td>Used for annual reports, posters, brochures, and magazines. Have gloss, dull, or matte finishes</td>
<td>10</td>
</tr>
<tr>
<td>Carbonless</td>
<td>Used for multiple-impact copy forms</td>
<td>30</td>
</tr>
<tr>
<td>File folders</td>
<td>Manila or colored</td>
<td>30</td>
</tr>
<tr>
<td>Dyed filing products</td>
<td>Used for multicolored hanging folders and wallet files</td>
<td>20</td>
</tr>
<tr>
<td>Index and card stock</td>
<td>Used for index cards and postcards</td>
<td>20</td>
</tr>
<tr>
<td>Pressboard</td>
<td>High-strength paperboard used in binders and report covers</td>
<td>20</td>
</tr>
<tr>
<td>Tags and tickets</td>
<td>Used for toll and lottery tickets, licenses, and</td>
<td>20</td>
</tr>
<tr>
<td>Product Type</td>
<td>Description</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Newsprint</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newsprint</td>
<td>Groundwood paper used in newspapers</td>
<td>20</td>
</tr>
<tr>
<td><strong>Commercial Sanitary Tissue Products</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom tissue</td>
<td>Used in rolls or sheets</td>
<td>20</td>
</tr>
<tr>
<td>Paper towels</td>
<td>Used in rolls or sheets</td>
<td>40</td>
</tr>
<tr>
<td>Paper napkins</td>
<td>Used in food service applications</td>
<td>30</td>
</tr>
<tr>
<td>Facial tissue</td>
<td>Used for personal care</td>
<td>10</td>
</tr>
<tr>
<td>General-purpose industrial wipers</td>
<td>Used in cleaning and wiping applications</td>
<td>40</td>
</tr>
<tr>
<td><strong>Paperboard and Packaging Products</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrugated containers (&lt;300 psi)</td>
<td>Used for packaging and shipping a variety of goods</td>
<td>25</td>
</tr>
<tr>
<td>Corrugated containers (300 psi)</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Solid fiber boxes</td>
<td>Used for specialized packaging needs such as dynamite packaging and army ration boxes</td>
<td>40</td>
</tr>
<tr>
<td>Folding cartons</td>
<td>Used to package a wide variety of foods, household products, cosmetics, pharmaceuticals, detergent, and hardware</td>
<td>40</td>
</tr>
<tr>
<td>Industrial paperboard</td>
<td>Used to create tubes, cores, cans and drums</td>
<td>45</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Includes “chipboard” pad backings, book covers, covered binders, mailing tubes, game boards, and puzzles</td>
<td>75</td>
</tr>
<tr>
<td>Padded mailers</td>
<td>Made from kraft paper that is usually brown but can be bleached white</td>
<td>5</td>
</tr>
<tr>
<td>Carrierboard</td>
<td>A type of folding carton designed for multipack beverage cartons</td>
<td>10</td>
</tr>
<tr>
<td>Brown papers</td>
<td>Used for bags and wrapping paper</td>
<td>5</td>
</tr>
<tr>
<td><strong>Miscellaneous Paper Products</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tray liners</td>
<td>Used to line food service trays. Often contain printed information.</td>
<td>50</td>
</tr>
</tbody>
</table>

“Post-consumer” content is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed its life as a consumer item. Post-consumer content is part of the broader category of recovered material.”

The Commonwealth of Pennsylvania recognizes that paper products are universally made with scrap material recovered from the manufacturing process; use of such materials is a standard practice, both efficient and economical for the paper maker; therefore, bidders of paper products need not certify that their products are made with “pre-consumer,” “recovered,” or “secondary” paper fiber.
(B) **BIDDER’S CERTIFICATION**

Bidder certifies that the paper product(s) which the bidder is offering contains the required minimum percentage of post-consumer content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a mill certification must be completed and signed by the mill before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE DELIVERED ITEM.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the paper product(s), to provide the Commonwealth with documentary evidence that the paper product(s) were in fact produced with the required minimum percentage of post-consumer content.
EXHIBIT A-4
LANDSCAPING PRODUCTS
RECYCLED CONTENT

(A) REQUIREMENT

All landscaping products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Landscaping Products</th>
<th>Recovered Material Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydraulic Mulch:</td>
<td></td>
</tr>
<tr>
<td>-----Paper</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>-----Wood/Paper</td>
<td>100% (total)</td>
</tr>
<tr>
<td>Compost Made From Yard Trimmings and/or Food Waste</td>
<td>Purchase or use compost made from yard trimmings, leaves, grass clippings and/or food wastes for applications such as landscaping, seeding of grass or other plants, as nutritious mulch under trees and shrubs, and in erosion control and soil reclamation. DGS further recommends implementing a composting system for these materials when agencies have an adequate volume and sufficient space.</td>
</tr>
<tr>
<td>Garden Hose:</td>
<td></td>
</tr>
<tr>
<td>-----Rubber and/or Plastic</td>
<td>60% (post-consumer)</td>
</tr>
<tr>
<td>Soaker Hose:</td>
<td></td>
</tr>
<tr>
<td>-----Rubber and/or Plastic</td>
<td>60% (post-consumer)</td>
</tr>
<tr>
<td>Lawn and Garden Edging:</td>
<td></td>
</tr>
<tr>
<td>-----Rubber and/or Plastic</td>
<td>30% (post-consumer)/30-100% (total)</td>
</tr>
<tr>
<td>Landscaping Timber and Posts:</td>
<td></td>
</tr>
<tr>
<td>-----HDPE</td>
<td>25% (post-consumer) + 50% (recovered)</td>
</tr>
<tr>
<td>-----Mixed Plastics/Sawdust</td>
<td>50% (post-consumer) + 50% (recovered)</td>
</tr>
<tr>
<td>-----HDPE/Fiberglass</td>
<td>75% (post-consumer) + 20% (recovered)</td>
</tr>
<tr>
<td>-----Other mixed Resins</td>
<td>50% (post-consumer) + 45% (recovered)</td>
</tr>
</tbody>
</table>

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed it life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

(B) BIDDER’S CERTIFICATION

Bidder certifies that the landscaping product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) MANUFACTURER/MILL CERTIFICATION

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE DELIVERED ITEM.

(D) ENFORCEMENT

Awarded bidders may be required, after delivery of the landscaping product(s), to provide the Commonwealth with documentary evidence that the landscaping product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
EXHIBIT A-5
MISCELLANEOUS PRODUCTS
RECYCLED CONTENT

(A) REQUIREMENT

All miscellaneous products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Miscellaneous Products</th>
<th>Recovered Material Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awards and Plaques</td>
<td></td>
</tr>
<tr>
<td>Glass</td>
<td>75% (post-consumer) + 25% (recovered)</td>
</tr>
<tr>
<td>Wood</td>
<td>100% (total)</td>
</tr>
<tr>
<td>Paper</td>
<td>40% (post-consumer)</td>
</tr>
<tr>
<td>Plastic and Plastic/Wood Composites</td>
<td>50% (post-consumer) + 45% (recovered)</td>
</tr>
<tr>
<td>Industrial Drums</td>
<td></td>
</tr>
<tr>
<td>Steel1</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>Plastic (HDPE)</td>
<td>30% (post-consumer)</td>
</tr>
<tr>
<td>Fiber (paper)</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>Mats</td>
<td></td>
</tr>
<tr>
<td>Rubber</td>
<td>75% (post-consumer) + 10% (recovered)</td>
</tr>
<tr>
<td>Plastic</td>
<td>10% (post-consumer) + 90% (recovered)</td>
</tr>
<tr>
<td>Rubber/Plastic Composite</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>Pallets</td>
<td></td>
</tr>
<tr>
<td>Wood</td>
<td>95% (post-consumer)</td>
</tr>
<tr>
<td>Plastic</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>Thermoformed</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Paperboard</td>
<td>50% (post-consumer)</td>
</tr>
<tr>
<td>Signage</td>
<td></td>
</tr>
<tr>
<td>Plastic</td>
<td>80% (post-consumer)</td>
</tr>
<tr>
<td>Aluminum</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Plastic Sign Posts/Supports</td>
<td>80% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>Steel Sign Posts/Supports2</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>Sorbents</td>
<td></td>
</tr>
<tr>
<td>Paper</td>
<td>90% (post-consumer) + 10% (recovered)</td>
</tr>
<tr>
<td>Textiles</td>
<td>95% (post-consumer)</td>
</tr>
<tr>
<td>Plastics</td>
<td>25% (total)</td>
</tr>
<tr>
<td>Wood3</td>
<td>100% (total)</td>
</tr>
<tr>
<td>Other Organics/Multimaterials4</td>
<td>100% (total)</td>
</tr>
<tr>
<td>Manual-Grade Strapping</td>
<td></td>
</tr>
<tr>
<td>Polyester</td>
<td>50% (post-consumer)</td>
</tr>
<tr>
<td>Polypropylene</td>
<td>10% (total)</td>
</tr>
<tr>
<td>Steel1</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>Steel2</td>
<td>67% (post-consumer) + 33% (recovered)</td>
</tr>
</tbody>
</table>

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed it life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

1 Steel used in steel drums is manufactured using the Basic Oxygen Furnace (BOF) process, which contains 25-30% total recovered material, of which 16% is post-consumer steel. Steel used in manual-grade strapping is manufactured using either the BOF process or the Electric Arc Furnace (EAF) process, which contains 100% total recovered materials, of which 67% is post-consumer steel.

2 The recommended recovered materials content levels for steel in this table reflect the fact that the designated items can be made from steel manufactured in either a Basic Oxygen Furnace (BOF) or an Electric Arc Furnace (EAF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel. Steel from the EAF process contains a total of 100% recovered steel, of which 67% is post-consumer.

3 “Wood” includes materials such as sawdust and lumber mill trimmings.

4 Examples of other organics include, but are not limited to, peanut hulls and corn stover. An example of multimaterial sorbents would include, but not be limited to, a polymer and cellulose fiber combination.

5 The recommended recovered materials content levels for steel in this table reflect the fact that the designated items can be made from steel manufactured in either a Basic Oxygen Furnace (BOF) or an Electric Arc Furnace (EAF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel. Steel from the EAF process contains a total of 100% recovered steel, of which 67% is post-consumer.
(B) **BIDDER’S CERTIFICATION**

Bidder certifies that the miscellaneous product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE DELIVERED ITEM.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the miscellaneous product(s), to provide the Commonwealth with documentary evidence that the miscellaneous product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
(A) **REQUIREMENT**

All nonpaper office products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth **must** contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Nonpaper Office Product</th>
<th>Recovered Material Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recycling Containers and Waste Receptacles</td>
<td></td>
</tr>
<tr>
<td>Plastic</td>
<td>20% (post-consumer)</td>
</tr>
<tr>
<td>Steel[1]</td>
<td>16% (post-consumer) +9% (recovered)</td>
</tr>
<tr>
<td>Paper</td>
<td></td>
</tr>
<tr>
<td>Solid Fiber Boxes</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Industrial Paperboard</td>
<td>40% (post-consumer) + 60% (recovered)</td>
</tr>
<tr>
<td>Plastic Desktop Accessories (polystyrene) including desk organizers, sorters, and trays, and memo, note, and pencil holders.</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Binders:</td>
<td></td>
</tr>
<tr>
<td>Plastic-Covered</td>
<td>25%</td>
</tr>
<tr>
<td>Paper-Covered</td>
<td>75% (post-consumer) +15% (recovered)</td>
</tr>
<tr>
<td>Pressboard</td>
<td>20% (post-consumer) + 30% (recovered)</td>
</tr>
<tr>
<td>Solid Plastic</td>
<td></td>
</tr>
<tr>
<td>HDPE</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>PE</td>
<td>30% (post-consumer)</td>
</tr>
<tr>
<td>PET</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>Misc. Plastics</td>
<td>80% (post-consumer)</td>
</tr>
<tr>
<td>Trash Bags (plastic)</td>
<td>10% (post-consumer)</td>
</tr>
<tr>
<td>Toner Cartridges</td>
<td>Return used toner cartridges for remanufacturing and reuse or purchase a remanufactured or recycled-content replacement cartridge.</td>
</tr>
<tr>
<td>Printer Ribbons</td>
<td>Procure printer ribbon reinking or reloading services or procure reinked or reloaded printer ribbons.</td>
</tr>
<tr>
<td>Plastic Envelopes</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Plastic Clipboards:</td>
<td></td>
</tr>
<tr>
<td>HDPE</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>PS</td>
<td>50% (post-consumer)</td>
</tr>
<tr>
<td>Misc. Plastics</td>
<td>15% (post-consumer)</td>
</tr>
<tr>
<td>Plastic File Folders</td>
<td></td>
</tr>
<tr>
<td>HDPE</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>Plastic Clip Portfolios</td>
<td></td>
</tr>
<tr>
<td>HDPE</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>Plastic Presentation Folders</td>
<td></td>
</tr>
<tr>
<td>HDPE</td>
<td>90% (post-consumer)</td>
</tr>
</tbody>
</table>

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed it life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

[1] The recommended recovered materials content levels for steel in this table reflect the fact that the designated item is made from steel manufactured from in a Basic Oxygen Furnace (BOF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel.
“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

(B) **BIDDER'S CERTIFICATION**

Bidder certifies that the nonpaper office products which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. **The Commonwealth shall have no obligation to pay for the item(s) until a properly completed and signed manufacturer/mill certification is submitted for the delivered item.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the paper, to provide the Commonwealth with documentary evidence that the nonpaper office product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
EXHIBIT A-7
PARK & RECREATION PRODUCTS
RECYCLED CONTENT

(A) **REQUIREMENT**

All park and recreation products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Park &amp; Recreation Product</th>
<th>Recovered Material Content¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park Benches &amp; Picnic Tables:</td>
<td>90% (post-consumer) + 10% (recovered)</td>
</tr>
<tr>
<td>-----Plastic²</td>
<td>50% (post-consumer) + 50% (recovered)</td>
</tr>
<tr>
<td>-----Plastic Composites</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>-----Aluminum</td>
<td>15% (total)</td>
</tr>
<tr>
<td>-----Concrete</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>-----Steel³</td>
<td>67% (post-consumer) + 33% (recovered)</td>
</tr>
<tr>
<td>Plastic Fencing for Specified Uses⁴</td>
<td>60% (post-consumer) + 30% (recovered)</td>
</tr>
<tr>
<td>Playground Equipment</td>
<td>90% (post-consumer) + 10% (recovered)</td>
</tr>
<tr>
<td>-----Plastic³</td>
<td>50% (post-consumer) + 45% (recovered)</td>
</tr>
<tr>
<td>-----Plastic Composites</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>-----Steel⁴</td>
<td>67% (post-consumer) + 33% (recovered)</td>
</tr>
<tr>
<td>-----Aluminum</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>Playground Surfaces:</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>-----Plastic or Rubber</td>
<td>90% (post-consumer)</td>
</tr>
<tr>
<td>Running Tracks:</td>
<td></td>
</tr>
<tr>
<td>-----Plastic or Rubber</td>
<td>90% (post-consumer)</td>
</tr>
</tbody>
</table>

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed its life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

(B) **BIDDER’S CERTIFICATION**

Bidder certifies that the park and recreational product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **The Commonwealth shall have no obligation to pay for the item(s) until a properly completed and signed Manufacturer/Mill Certification is submitted for the delivered item.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the park and recreational product(s), to provide the Commonwealth with documentary evidence that the park and recreational product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.

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¹ The recommended recovered materials content levels are based on the dry weight of the raw materials, exclusive of any additives such as adhesives, binders, or coloring agents.

² “Plastic” includes both single and mixed plastic resins. Park benches and picnic tables made with recovered plastic may also contain other recovered materials such as sawdust, wood, or fiberglass. The percentage of these materials contained in the product would also count toward the recovered materials content level of the item.

³ The recommended recovered materials content levels for steel in this table reflect the fact that the designated items can be made from steel manufactured from either a Basic Oxygen Furnace (BOF) or an Electric Arc Furnace (AF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel. Steel from the EAF process contains a total of 100% recovered steel, of which 67% is post-consumer.

⁴ Designation includes fencing containing recovered plastic for use in controlling snow or sand drifting and as a warning/safety barrier in construction or other applications.
EXHIBIT A-8
TRANSPORTATION PRODUCTS
RECYCLED CONTENT

(A) **REQUIREMENT**

All transportation products offered by the bidder, or included in the final product offered by the bidder, and sold to the Commonwealth must contain the minimum percentage of post-consumer and recovered material content as shown below for the applicable products:

<table>
<thead>
<tr>
<th>Transportation Products</th>
<th>Recovered Material Content¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traffic Cones:</td>
<td></td>
</tr>
<tr>
<td>-----Plastic (PVC and LDPE)</td>
<td>50% (recovered)</td>
</tr>
<tr>
<td>-----Crumb Rubber</td>
<td>50% (recovered)</td>
</tr>
<tr>
<td>Traffic Barricades (type I and II only):</td>
<td></td>
</tr>
<tr>
<td>-----Plastic (HDPE, LDPE, PET)</td>
<td>80% (post-consumer) + 20% (recovered)</td>
</tr>
<tr>
<td>-----Steel²</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>-----Fiberglass</td>
<td>67% (post-consumer) + 33% (recovered)</td>
</tr>
<tr>
<td>Parking Stops:</td>
<td></td>
</tr>
<tr>
<td>-----Plastic and/or Rubber</td>
<td>100% (recovered)</td>
</tr>
<tr>
<td>-----Concrete Containing Coal Fly Ash</td>
<td>20% (recovered)</td>
</tr>
<tr>
<td>-----Concrete Containing Ground</td>
<td>15% when used as a partial cement replacement as an admixture in concrete.</td>
</tr>
<tr>
<td>Granulated Blast Furnace Slag</td>
<td>25% (recovered)</td>
</tr>
<tr>
<td>Traffic Control Devices:</td>
<td></td>
</tr>
<tr>
<td>-----Channelizers:</td>
<td></td>
</tr>
<tr>
<td>------Plastic</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>------Rubber (base only)</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>------Delineators:</td>
<td></td>
</tr>
<tr>
<td>------Plastic</td>
<td>25% (post-consumer)</td>
</tr>
<tr>
<td>------Rubber (base only)</td>
<td>100% (post-consumer)</td>
</tr>
<tr>
<td>------Steel (base only)²</td>
<td>16% (post-consumer) + 9% (recovered)</td>
</tr>
<tr>
<td>------Flexible Delineators</td>
<td>67% (post-consumer) + 33% (recovered)</td>
</tr>
</tbody>
</table>

¹ Content levels are based on the dry weight of the raw materials, exclusive of any additives such as adhesives, binders, or coloring agents.

² The recommended recovered materials content levels for steel in this table reflect the fact that the designated items can be made from steel manufactured from either a Basic Oxygen Furnace (BOF) or an Electric Arc Furnace (EAF). Steel from the BOF process contains 25-30% total recovered materials, of which 16% is post-consumer steel. Steel from the EAF process contains a total of 100% recovered steel, of which 67% is post-consumer.

“Post-consumer” material is “material or finished product that has served its intended use and has been diverted or recovered from waste destined for disposal, having completed its life as a consumer item. Post-consumer material is part of the broader category of recovered material.”

“Recovered Materials” refers to waste materials and by-products which have been recovered or diverted from solid waste, but does not include those materials and by-products generated from, and commonly reused within, an original manufacturing process.

(B) **BIDDER’S CERTIFICATION**

Bidder certifies that the transportation product(s) which the bidder is offering contains the required minimum percentage of post-consumer and recovered material content as shown above for the product.

(C) **MANUFACTURER/MILL CERTIFICATION**

In addition to the Bidders Certification in Subsection (B), a manufacturer certification must be completed and signed by the manufacturer before payment will be made to the successful bidder for the delivered items. The enclosed Manufacturer/Mill Certification form must be used. Bidders are not required to submit the completed and signed Manufacturer/Mill Certification form with their bids. **THE COMMONWEALTH SHALL HAVE NO OBLIGATION TO PAY FOR THE ITEM(S) UNTIL A PROPERLY COMPLETED AND SIGNED MANUFACTURER/MILL CERTIFICATION IS SUBMITTED FOR THE DELIVERED ITEM.**

(D) **ENFORCEMENT**

Awarded bidders may be required, after delivery of the transportation product(s), to provide the Commonwealth with documentary evidence that the transportation product(s) were in fact produced with the required minimum percentage of post-consumer and recovered material content.
MANUFACTURER/MILL CERTIFICATION

(To be submitted with invoice for each order)

TO BE COMPLETED BY MANUFACTURER/MILL:

NAME OF MANUFACTURER/MILL: _____________________________________________________

ADDRESS OF MANUFACTURER/MILL: __________________________________________________

FEDERAL EMPLOYER I.D. NO.: _________________________________________________________

CONTRACT OR REQUISITION NO. ______________________________________________________

NAME OF CONTRACTOR: ______________________________________________________________

ADDRESS OF CONTRACTOR: ___________________________________________________________

Type of product(s) which the manufacturer/mill furnished to the contractor: _________________________

CERTIFICATION: I, the undersigned officer of the above-named manufacturer/mill, do hereby certify that I am 
authorized to provide this certification on behalf of the above-named manufacturer/mill and that the type of 
product(s) listed above which my company furnished to the contractor named above for the referenced contract or 
purchase requisition, contained not less than ______% post-consumer materials and ______% recovered materials 
as those terms are defined in the invitation for bids. I understand that this document is subject to the provisions of 
the Unsworn Falsification of Authorities Act (18 P.S. Section 4904).

______________________________
Signature

______________________________
Name of Signatory

______________________________
Title Date
CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS
(Applicable to contracts $25,000 or more)

1. The successful contractor, within 10 days of receiving the notice to proceed, shall contact the Employment Unit Coordinator in the County Assistance Office in the county where the contractor delivers the service to present, for review and approval, contractor’s plan for recruiting and hiring of public assistance recipients for employment under this contract. Contractors which provide services through the contract to more than one county shall present their plan for review and approval to the Central Office of Employment and Training. Such plan shall be submitted on Form PA 778. A copy of the contractor’s approved plan shall be returned within 30 days of notice to proceed to the initiating office/facility.

2. Pursuant to the approved plan, the contractor shall make a good faith effort to fill at least 25% of the new or vacant jobs created under this contract with qualified recipients referred by the County Assistance Office Employment Unit Coordinator.

3. Hiring under the approved plan shall be verified by Quarterly Contract Reports on Form PA 1540 to the Employment Unit Coordinator or to the Central Office of Employment and Training for plans covering more than one county. Such reports shall be made in the format approved by the Department.

4. The Department may cancel this contract upon thirty (30) days written notice in the event of contractor’s failure to implement or abide by an approved plan.
LOBBYING CERTIFICATION AND DISCLOSURE OF LOBBYING ACTIVITIES
Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his/her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employees of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any federal grant, the making of any federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all times including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements, and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, and U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: ________________________________________

TITLE: ______________________________________________

DATE: ______________________________________________
INSTRUCTIONS FOR COMPLETION OF DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub-awardee or prime federal client, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of Member of Congress in connection with a covered federal action. Use the Standard Form-LLL-A, "Continuation Sheet," for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award client. Identify the tier of the sub-awardee, e.g., the first sub-awardee of the prime is the 1st tier. Sub-awards include but are not limited to subcontracts, sub-grants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Sub-awardee," then enter the full name, address, city, state, and zip code of the prime federal client. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1, e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency. Include prefixes, e.g., "RFP-DE-80-001."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award loan commitment for the prime entity identified in Item 4 or 5.

10. A. Enter the full name, address, city, state, and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered federal action.

B. Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the rate and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contract with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a Standard Form-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minute per reports, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing the burden, to the Office of Management and Budget, Paperwork Reduction Project (CC-48-004), Washington, D.C., 30603.
**DISCLOSURE OF LOBBYING ACTIVITIES**

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
<th>2. Status of Federal Action:</th>
<th>3. Report Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract</td>
<td>Bid/Offer Application</td>
<td>a. Initial Filing</td>
</tr>
<tr>
<td>a. Grant</td>
<td>a. Initial Award</td>
<td>b. Material Change</td>
</tr>
<tr>
<td>b. Cooperative Agreement</td>
<td>b. Post-Award</td>
<td>For Material Change:</td>
</tr>
<tr>
<td>c. Loan</td>
<td></td>
<td>Year _______ Quarter _______</td>
</tr>
<tr>
<td>d. Loan Guarantee</td>
<td></td>
<td>Date of last report ____________</td>
</tr>
<tr>
<td>e. Loan Insurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Name and Address of Reporting Entity:
   Prime                     Subawardee
   Tier _____ if
   known:                    
   Congressional District, if known

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
   Congressional District, if known

6. Federal Department/Agency:

7. Federal Program Name/Description:
   CFDA Number, if applicable: ___________________

8. Federal Action Number, if known:

9. Award Amount, if known:
   $

10. a. Name and Address of Lobbying Entity
    (if individual, last name, first name, MI):

    (attach Continuation Sheet(s) SF-LLL-A, if necessary)
    b. Individuals Performing Services (including address if different from No. 10a)
       (last name, first name, MI)

11. Amount of Payment (check all that apply):
    $_________________  actual  planned

12. Form of Payment (check all that apply):
    a. Cash
    b. In-kind: Specify: Nature ________
       Value ________

13. Type of Payment
    a. retainer
    b. one-time fee
    c. commission
    d. contingent fee
    e. deferred
    f. other; specify: ____________________

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employe(s) or Member(s) contacted, for payment indicated in Item 11:

    (attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached:  Yes  No
16. Information required through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and no more than $100,000 for each such failure.

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Federal Use Only:  Authorized for Local Reproduction Standard Form - LLL
DISCLOSURE OF LOBBYING ACTIVITIES
Continuation Sheet

Reporting Entry:_________________________ Page _____ of _____
PAY FOR PERFORMANCE PROGRAM

A. OVERVIEW

The Department is implementing a Pay for Performance Program (P4P) beginning January 1, 2008 for counties in the Lehigh/Capital, Southeast and Southwest zones that provides both financial and non-financial incentives for the HealthChoices Behavioral Health Primary Contractor that meet quality goals. P4P is aligned with the goals of the Prescription for Pennsylvania initiative in that it is an incentive program that rewards the Primary Contractor for gains in quality of care for behavioral health services provided to the HealthChoices Members in their county.

The Department identified six (6) PA-specific core quality performance indicators designated for financial incentives based on measurability and reliable data.

Upon review and validation of supporting data, the Primary Contractor will be eligible for a financial incentive of a portion of up to one-half of a percent of the total capitation payment, net of the MCO Assessment, paid by the Department for eligible Members during a Measurement Period in the HealthChoices zone in which the Primary Contractor is located. The maximum incentive payment to which a Primary Contractor may be entitled will be determined by multiplying the Primary Contractor’s percentage share of all Members in the applicable HealthChoices zone times the amount of the total capitation payment to be made during the Measurement Period. A Measurement Period will be a calendar year, commencing January 1, 2008. Validation of supporting data will occur by the eighth month following the Measurement Period, with any eligible incentive payment made to the Primary Contractor in the fourth quarter of the year following the Measurement Period.

Incentives will be developed and administered in accordance with 42 CFR 438.6. Financial incentives available through P4P will be paid in addition to the actuarially sound capitation rates to be paid by the Department to each Primary Contractor.
B. PERFORMANCE INDICATORS

The following six (6) PA-specific core performance indicators designated for financial incentive comprise the initial year P4P (January 1, 2008 – December 31, 2008):

1) Follow-up from psychiatric inpatient discharge at seven (7) days, age 6 - 20
2) Follow-up from psychiatric inpatient discharge at seven (7) days, age 21 - 64
3) Follow-up from psychiatric inpatient discharge at thirty (30) days, age 6 - 20
4) Follow-up after psychiatric inpatient discharge at thirty (30) days, age 21 – 64
5) Readmissions to psychiatric inpatient hospitalization within thirty (30) days following discharge from psychiatric inpatient hospitalization, age under 21
6) Readmissions to psychiatric inpatient hospitalization within thirty (30) days following discharge from psychiatric inpatient hospitalization, age 21 - 64

The goal for B.1) – B.4) is to achieve a high level of follow-up and improve performance from the baseline year. The goal for B.5) and B.6) is to achieve a low level of readmission and decrease the rate from the baseline year.

C. PERFORMANCE INCENTIVES

1. FINANCIAL

a. Performance Incentive

The Primary Contractor may earn a performance incentive payment based on their performance in 2008 compared to the baseline. The baseline is a defined set of rates calculated from the 2006 HealthChoices rates. The baseline rates range from 50% (the value that represents the mid point of performance in 2006) to 100% (the top performance in 2006).

b. Performance Target

Follow-up or readmission scores for the 50th to 100th percentile rankings were computed by subtracting the score at the 50th percentile from the score at the 100th percentile and dividing this difference by 50. This yielded a 50 step rank of scores associated with performance incentive payments from 50% to 100%.

The performance incentive payment is determined by where the Primary Contractor’s 2008 actual performance falls within the ranking.

- Below the 2006 50th percentile – 0% of performance incentive payment
- 50th to 99th percentile – 50% to 100% according to performance ranking
2) NON-FINANCIAL

- The five Primary Contractors achieving the highest performance on each indicator will be presented with a special certificate and recognition at a DPW advisory committee meeting.
- Primary Contractors performing at or above the baseline 50th percentile on each indicator will receive a certificate.
- The results of the P4P will be placed on the DPW website and presented at the Medical Assistance Advisory Committee meeting.

D. METHODOLOGY FOR IMPROVEMENT INCENTIVES

a. Improvement Incentive

The Primary Contractor is eligible to receive an additional incentive payment if they show improvement. Primary Contractors that score below the 50th percentile in 2008 will receive no performance payment, but are eligible to receive up to a 25% improvement award. Primary Contractors that score at the 50th percentile or above will be eligible for an improvement payment of between 2% and 25% based on the amount of improvement. The better the performance score to begin with, the more difficult it is to make improvement, thus a higher improvement incentive per point of improvement.

b. Improvement Targets

- Performance below 50%
  - 1 percentage point improvement – 5% of incentive payment
  - 2 percentage point improvement – 10% of incentive payment
  - 3 percentage point improvement – 15% of incentive payment
  - 4 percentage point improvement – 20% of incentive payment
  - 5 percentage point improvement – 25% of incentive payment

- Performance in the 50% to 59% range
  - 1 percentage point improvement – 2% of incentive payment
  - 2 percentage point improvement – 4% of incentive payment
  - 3 percentage point improvement – 6% of incentive payment
  - 4 percentage point improvement – 8% of incentive payment
  - 5 percentage point improvement – 10% of incentive payment

- Performance in the 60% to 69% range
  - 1 percentage point improvement – 3% of incentive payment
  - 2 percentage point improvement – 6% of incentive payment
  - 3 percentage point improvement – 9% of incentive payment
  - 4 percentage point improvement – 12% of incentive payment
  - 5 percentage point improvement – 15% of incentive payment
Appendix E
January 1, 2008

E. Payment for Performance Incentives

The Department will inform the Primary Contractor of the incentive payment amount by the fourth quarter of the year following the Measurement Period. The incentive payment amount will be equivalent to:

1) Capitation Revenue: one-half of a percent of the Primary Contractor’s capitation revenue earned, net of the MCO Assessment, or applicable, to the Measurement Period.

2) Payment will be allocated by zone and by each Primary Contractor’s membership percentage within the HealthChoices Behavioral Health zone applicable to the Measurement Period, determined on June 30 following the Measurement Period and inclusive of all retroactive eligibility adjustments.

3) The Primary Contractor will be notified within 120 days of the start of each Measurement Period with respect to renewal of the P4P, as funds are available.

4) The maximum payment will be allocated as follows:
   a) Performance Indicators in B.1 and B.2 will have 15% of the maximum payment applied to each as the eligible incentive; and
   b) Performance Indicators in B.3 and B.4 will have 10% of the maximum payment applied to each as the eligible incentive.
   c) Performance Indicators in B.5 and B.6 will have 25% of the maximum payment applied to each as the eligible incentive.

5) The incentive payments will not exceed 105% of capitation payments, nor will they be conditioned on an Intergovernmental Transfer, in accordance with Federal regulation. Incentive payments can be made to both public and private providers.
Fraud and Abuse Program Requirements

Definitions:

Abuse – Any practices in a capitated MCO, Primary Care Case Management (PCCM) program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practice and which result in unnecessary cost to the MA Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the PSR, contracts, and requirements of state or federal regulations) for health care in the managed care setting. The abuse can be committed by an MCO, contractor, Subcontractor, Provider, State employee, MA beneficiary or MA managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary costs to the MA program or MCO, contractor, Subcontractor, or Provider. A Provider can be described as any individual or entity that receives MA funds in exchange for providing a service (MCO, contractor or Subcontractor).

Fraud – Any intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in an unauthorized benefit to the entity, him/herself or another responsible person in a managed care setting.

1. Primary Contractor’s Responsibility for Fraud and Abuse Requirements of the HealthChoices Contract

The Primary Contractor shall develop or require the BHMCs to develop a written compliance plan that must contain the following elements described in CMS publication “Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans” found at [http://www.cms.hhs.gov/states/fraud](http://www.cms.hhs.gov/states/fraud)

- Written policies, procedures and standards of conduct that articulate the organization’s commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- The designation of a compliance officer and a compliance committee that is accountable to senior management;
- Effective training and education for the compliance officer and MCO employees;
- Effective lines of communication between the compliance officer and MCO employees;
- Enforcement of standards through well publicized disciplinary guidelines;
- Provisions for internal monitoring and auditing; and
- Provisions for prompt response to detected offenses and the development of corrective action initiatives.

The Primary Contractor shall designate a Fraud and Abuse Coordinator who will be responsible for preventing, detecting, investigating, and referring suspected fraud and abuse in the HealthChoices behavioral health program to the Department. The Fraud and Abuse Coordinator will act as a direct contact with the Department in matters
relating to fraud and abuse. The Primary Contractor shall submit the name, address, title, and contact information of the Coordinator to the Department.

The Primary Contractor may designate the BH-MCO to fulfill the function of managing the HealthChoices fraud and abuse requirements and, in this event, shall submit policies and procedures describing the measures taken to ensure that the BH-MCO complies with all requirements related to fraud and abuse. In this instance the Primary Contractor shall provide oversight of the BH-MCO and shall require the BH-MCO to report all cases of suspected fraud or abuse to the primary contractor and the Department.

2. Fraud and Abuse Requirements for HealthChoices

   a. Corporate Integrity / Compliance / Fraud and Abuse Staff
   The Primary Contractor or BH-MCO shall have experienced fraud and abuse staff that shall prevent, detect, investigate, and report suspected fraud and abuse that may be committed by network Providers, members, employees, and subcontracted parties.

   b. Written Policies
   The Primary Contractor or BH-MCO shall maintain and comply with written policies and procedures for the prevention, detection, and reporting of suspected fraud and abuse, which are subject to the approval of the Department’s Bureau of Program Integrity.

   The Department may require new or updated policies and procedures during the course of the contract period. The policies and procedures shall contain the following:
   • The name, title, and contact information of the Fraud and Abuse Coordinator and staff.
   • A description of specific controls in place for fraud and abuse detection, including an explanation of the technology used to identify aberrant billing patterns, procedures for claims edits and post processing review of claims, review of complaints and grievances, and other means of identifying fraud and abuse.
   • A description of the methodology and standard operating procedures used to investigate fraud and abuse, such as on-site visits and record reviews.
   • Explanation of the process for referring suspected fraud and abuse to the Department within thirty (30) business days of identification of the problem/issue. This explanation shall state that the MCO must gather and send to BPI any and all documentation supporting the referral. Such information will include, but will not be limited to, the items listed on the "Checklist of Supporting Documentation for Referrals" (Attachment 5).
   • Methodology for recovering overpayments or otherwise sanctioning Providers.
   • Process for reporting in writing any Providers who are suspended, resign, or voluntarily withdraw after initiation of fraud and abuse review.
• A statement outlining an educational plan for staff relating to fraud and abuse.
• Statement ensuring full cooperation with state and federal oversight agencies including, but not limited to, the Department’s Bureau of Program Integrity, the Office of Attorney General’s Medicaid Fraud Control Section, The Pennsylvania Office of the Inspector General, and the US Justice Department.
• A statement that the Department’s Medicheck List and the Federal Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) are used to verify that Providers sanctioned by the state or federal government are not participating in HealthChoices.
• A method to verify whether services reimbursed by the Primary Contractor and/or its BH-MCO were actually furnished to recipients.
• A certification that the policies and procedures were reviewed and approved by the Primary Contractor or BH-MCO

c. Duty to Report Suspected Fraud and Abuse to the Department
The Fraud and Abuse Coordinator shall be required to report all suspected fraud and abuse to the Department within thirty (30) business days of the identification of the problem/issue or pattern of abuse. The Fraud and Abuse Coordinator is responsible for assembling all documentation supporting the referral and sending it to BPI. “MCO Fraud and Abuse Reporting Requirements” (Attachment 1) provides examples of fraud and abuse, as well as reporting information to the Department. The "Checklist of Supporting Documentation for Referrals" (Attachment 5) includes examples of the information that the MCO must gather and send to BPI in order to support a referral. The Fraud and Abuse Coordinator should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form indicating the supporting documentation information that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. All suspected fraud and abuse shall be reported prior to any internal sanctioning, including corrective actions by the Primary Contractor or BH-MCO.

The Fraud and Abuse Coordinator shall submit to the Department quarterly statistical reports which detail its Fraud and Abuse detection and sanctioning activities regarding Providers.

The quarterly report should include information for all situations where a Provider action caused an overpayment to occur. The quarterly report will identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, and overpayments recovered. The “MCO Quarterly Compliance Report” and instructions for completion are located online at http://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/general/forms/instruct_mcompliance.asp. Upon completion of the Quarterly Compliance Report copy the spreadsheets and attach them to your secure email and send it to the email address provided in the
instructions. The MCO must provide a quarterly certification statement signed by either the Chief Executive Officer, the Chief Financial Officer or the Chief Operations Officer and the SIU Manager/Compliance Officer with every reporting package being submitted. If revisions are made to any report, an additional quarterly certification statement must accompany the revised report being sent to DPW.

d. Duty to Cooperate with Oversight Agencies
The Primary Contractor and/or its BH-MCO shall cooperate fully with state 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 Federal Office of Inspector General, and the United States Justice Department.

Such cooperation shall 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.

The Primary Contractor and/or its BH-MCO must immediately notify the Department, Bureau of Program Integrity, when a Provider, as well as other parties associated with Provider entity, has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making an application to be credentialed as a BH-MCO network Provider or upon renewal of their credentialing. The Primary Contractor or its BH-MCO shall also notify the Department, Bureau of Program Integrity of an adverse action, such as convictions, exclusions, revocations, and suspensions, taken on Provider applications, including denial of initial enrollment. Disclosure includes the following information:

- Identity of any person or entity having an ownership or control interest in the Provider and who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

- Identity of any person who is managing employee of the Provider and who has been convicted of a crime related to Federal health care programs.

- Identity of any person who is an agent of the Provider and who has been convicted of a crime related to Federal health care programs.

The Primary Contractor and/or its BH-MCO must supply updated disclosure to the Department within fifteen (15) days upon request.
e. Fraud and Abuse Hotline
The Primary Contractor and/or its BH-MCO must also ensure that the Department's toll-free fraud and abuse hotline and accompanying explanatory statement (Attachment 4) is distributed to Members and Providers through Member and Provider handbooks. Notwithstanding this requirement, the Primary Contractor or BH-MCO will not be required to re-print handbooks for the sole purpose of revising them to include fraud and abuse hotline information. The Primary Contractor or BH-MCO must, however, include such information in any new version of these documents to be distributed to Members and Providers.

f. Precluded Providers
The Primary Contractor and the BH-MCO are prohibited from affiliating with individuals who have been debarred from such Federal agencies as Medicaid, Medicare and SCHIP. Federal Financial Participation (FFP) is not available to pay for services from a Provider who is excluded from these programs, except for emergency services.

The Department shall notify Primary Contractors when actions are taken to terminate behavioral health Providers from participation in the Medicaid and Medicare Programs. The notification will not include the basis for the departmental action, due to confidentiality issues. Upon notification from the Department that a Provider is suspended or terminated from participation in the Medicaid or Medicare Programs, BH-MCO shall immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

The Department recommends that the Primary Contractor / BH-MCO access the Office of Medical Assistance Program’s Medicheck List at http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/AdvocatesS
takeholders/FraudAbuse/003673510.aspx for information on Providers who have been precluded from the MA Program. The Centers for Medicare and Medicaid Services (CMS) also recommend the Federal List of Excluded Individuals and Entities (LEIE) be checked monthly by accessing http://oig.hhs.gov/fraud/exclusions.asp and EPLS Excluded Parties list at www.epls.gov.

g. Duty to Notify Department
The Primary Contractor or BH-MCO must immediately notify the Department in writing if a Provider, Subcontractor, or employee resigns, is suspended, terminated, decertified or voluntarily withdraws from participation in the
network as a result of suspected or confirmed fraud or abuse. The notification must contain the reason for the action.

Provider agreements shall carry notification of the prohibition and sanctions for submission of false claims and statements. Primary Contractor or BH-MCOs who fail to report such information are subject to sanctions, penalties, or other actions.

h. Sanctions
The Department reserves the right to impose sanctions, penalties, or take other actions if it determines that a Primary Contractor, BH-MCO, network Provider, employee, or Subcontractor has committed fraud or abuse or has otherwise violated applicable law.

i. Subcontracts
The Primary Contractor and BH-MCO agree to ensure that all Subcontractors comply with the fraud and abuse requirements listed in this Agreement. In addition, although all health care Providers with whom the Primary Contractor and BH-MCO Subcontracts are enrolled in the MA program and subject to MA regulations, the Primary Contractor and BH-MCO agrees to ensure, via contract, that such health care Providers comply with MA regulations, and understand and agree that they are subject to enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.
Attachment 1
MCO FRAUD AND ABUSE REPORTING REQUIREMENTS

1. Examples of Suspected Fraud and Abuse: The following are examples of suspected fraud and abuse that must be reported. Contractor may reference 55 Pa. Code Section 1101 et seq. and the specific regulations relating to each provider type for further guidance.

Billing / Record Keeping Issues
- Falsifying/altering claims/ encounters/records
- Upcoding / Incorrect coding
- Double billing / Unbundling
- Billing for services/ supplies not rendered
- Failing to maintain appropriate records
- Any issue that could result in collection of overpayment

Suspected Member Fraud / Abuse
- Prescription alteration or forgery
- Inappropriate use of member’s card
- Duplication of medications/services
- Frequent ER visits; physician, pharmacy, or hospital “shopping”

Abuse of a Member
- Physical, mental, sexual
- Discrimination

Employee / Subcontractor Theft or Embezzlement

2. Reporting Suspected Provider Fraud and Abuse: The Contractor’s fraud and abuse unit must report suspected provider fraud and abuse within 5 business days.

Submit “MCO Standardized Reporting / Referral Process Form” by Fax to:
717-772-4655 (Attn: MCO Unit) or by mail to:
DPW Bureau of Program Integrity
Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675

3. Reporting Suspected Member Fraud and Abuse: Report to:
DPW Bureau of Program Integrity
Recipient Restriction Program
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717-772-4655 (fax)
Appendix F Attachment 2
MCO REPORTING FORM: PROVIDER SUBJECT OF TARGETED REVIEW

MCO REPORTING: ___________________________ DATE: ____________

PROVIDER NAME: ____________________________________ MA ID#: _____________

PROVIDER ADDRESS: ____________________________________ PROVIDER TYPE: ______

DESCRIBE THE ISSUE UNDER REVIEW, CITING THE PROCEDURE CODES & DESCRIPTIONS, DATES OF SERVICE, ETC. INDICATE HOW THE INFORMATION CAME TO YOUR ATTENTION.
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Please indicate the category of report (check one):
• MCO reporting only (MCO at this time plans to conduct review and take independent action) __________
• MCO reporting and requesting BPI involvement (guidance, technical assistance, * joint review) ________
• MCO referring case & requesting BPI take case or evaluate for referral to Medicaid Fraud Control Section ____
• Other (describe): _________________________________________________________________________

*For technical assistance BPI will respond within 2 weeks of receiving the report.

In cases in which the MCO intends to conduct the review, please indicate plan of action, i.e. medical record review, on-site visit, interviews of members, provider, provider staff):
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Reminder: In cases in which MCO conducts the review, the status, outcome, and any overpayments received are to be reported on the MCO Quarterly Targeted Review Form. Please submit report to Bureau of Program Integrity at P.O. Box 2675 Harrisburg, Pa. 17105-2675 or by fax to: (717) 772-4655, Attn: MCO UNIT
# QUARTERLY PROGRAM INTEGRITY REPORT

**PLAN NAME:** ___________________________  **Quarter/Year:** ___________________________

## Provider Activity for Current Quarter

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## Sanctions/Terminations Due to Review/Medicheck/LEIE

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## Recoveries/Cost Adjustments Due to Targeted Review

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DPW’s Toll-Free Fraud and Abuse Hotline
Information for Inclusion in MCO Member and Provider Manuals

For Member Handbooks:

DPW Fraud and Abuse Hotline:
The Department of Public Welfare has a hotline if you want to report a medical provider (for example a doctor, dentist, therapist, hospital) or business (medical supplier) for suspected fraud or abuse for services provided to anyone with an ACCESS card). The hotline number is 1-866-DPW-TIPS (1-866-379-8477).

Some common examples of fraud and abuse are:
Billing or charging you for services that your health plan covers
Offering you gifts or money to receive treatment or services
Offering you free services, equipment, or supplies in exchange for your ACCESS number
Giving you treatment or services that you don’t need
Physical, mental, or sexual abuse by medical staff

You can call the Hotline and speak to someone Monday through Friday, 8:30AM to 3:30PM. You may leave a voice mail message at other times. If you don’t speak English an interpreter will be made available. If you are hearing impaired you can call the hotline using your TTY device.

You do not have to give your name and if you do, the provider will not be told you called.

You can also report suspected fraud and abuse by using the website: http://www.dpw.state.pa.us/omap or email mailto:omaptips@state.pa.us. This has been set up so you do not have to give your name also.

For Provider Handbooks:
The Department of Public Welfare has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DPW-TIPS (1-866-379-8477) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Some common examples of fraud and abuse are:
Billing or charging Medical Assistance recipients for covered services
Billing more than once for the same service
Dispensing generic drugs and billing for brand name drugs
Falsifying records
Performing inappropriate or unnecessary services

Suspected fraud and abuse may also be reported via the website at: http://www.dpw.state.pa.us/omap or emailed to mailto:omaptips@state.pa.us. Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.
HEALTHCHOICES ENROLLMENT PROGRAM

The HealthChoices Enrollment Program contracts with an enrollment broker that is responsible for enrollment activities within all HealthChoices Zones. The enrollment broker employs trained professional staff called Enrollment Specialists (ESs) that are supervised by Special Needs Enrollment Coordinators (SNECs). The enrollment broker is responsible for educating the consumer, which enables them to make an informed choice of a physical health plan that best serves their medical needs and to assist with selecting a primary care physician (PCP).

The enrollment broker offers MA consumers several convenient methods of enrolling into the HealthChoices Program. All eligible Medicaid consumers have the opportunity to meet face-to-face with an ES with County Assistance Offices (CAOs). Other methods of enrolling include attending community presentations, using the HealthChoices Smart phone installed at the CAO which connects directly with an ES at the HC hotline, calling the toll-free HealthChoices hotline or by completing an enrollment form and returning it in the mail.

The enrollment broker will have Special Needs Coordinator (SNEC) serve as liaisons and work with County and State children and youth agencies; children in substitute care, county and state mental retardation agencies, aging, social programs, maternal and child health; and physical and behavioral health plans. The SNECS will assist Medicaid consumers who encounter obstacles enrolling into HealthChoices.

Once the Medicaid consumer enrolls into HealthChoices, the enrollment broker will enter this data onto their system and will submit on a weekly basis an enrollment/disenrollment file to the Department. The Department will send weekly enrollment/plan transfer reconciliation files to the enrollment broker and to the physical health plans.

The enrollment broker will be responsible for maintaining an on-line provider directory. This directory contains the provider network submitted by the physical health plans and is updated weekly.
Responsibilities of the enrollment broker include, but are not limited to the following:

- To help increase public awareness of the HealthChoices Program through conducting the CLIC and by coordinating efforts of the Public Information Campaign which provides general information to Medicaid consumers on mandatory managed care in Pennsylvania.

- To ensure that outreach efforts are specifically targeted to the various populations and needs of the Medicaid consumers in all HC-zones.

- To provide education and information to Medicaid consumers to enable them to make informed decisions on which physical health plans meets their needs in order to decrease plan transfers and encourage continuity of care.

- To ensure objective awareness of choices available for physical health care services.

- To provide information on the HC-BH-MCOs and how to access these services.

- To minimize the number of Medicaid consumers assigned to a physical health plan through automatic assignment.

- To complete enrollments and ensure that they are processed accurately, timely, efficiently, and effectively.

- To ensure the appropriate identification and referral of individuals with special needs or circumstances.
APPENDIX H
Complaint, Grievance, and Fair Hearing Processes

A. General Requirements

1. The BH-MCO must have written policies and procedures for registering, responding to and resolving complaints and grievances (at all levels) as they relate to the MA population.

2. All complaint, grievance, and fair hearing policies and procedures developed by a BH-MCO must be approved in writing by the Department prior to their implementation.

3. The complaint and grievance process must be fair, easy to understand, easy to follow, easily accessible and respectful of individual rights.

4. The BH-MCO policies and procedures regarding member complaints and grievances must be provided to members in written form:
   a. Upon enrollment into the BH-MCO,
   b. Upon member request, and
   c. At least 30 days prior to implementation of procedural revisions.

5. Information regarding the complaint and grievance procedures and how to file a complaint or grievance must be available within public view at all network provider offices.

6. The BH-MCO may not charge a member a fee for filing a complaint or grievance at any level of the process.

7. The BH-MCO must operate a toll-free telephone service for members to file complaints and grievances and to follow up on complaints and grievances filed by members. The phone service will be operated 24 hours a day, 7 days a week with appropriately trained staff. Answering machines or taped messages are not acceptable.

8. The BH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to member complaints and grievances in accordance with the requirements in this Appendix.

9. The BH-MCO must identify a lead person responsible for overall coordination of the complaint and grievance processes, including the provision of information and instructions to members.
10. Staff performing complaint and grievance reviews must have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.

11. The BH-MCO must maintain a log of all complaints and grievances, which includes, at a minimum, identifying information about the member, the nature of the complaint or grievance, and the date received.

12. The BH-MCO must ensure that members have access to all relevant documentation pertaining to the subject of the complaint or grievance.

13. The BH-MCO must ensure that there is a link between the complaint and grievance processes and the Quality Management and Utilization Management programs.

14. The BH-MCO may not use the timeframes or procedures of the complaint and grievance process to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner.

15. The BH-MCO must accept complaints and grievances from individuals with disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and complaints and grievances from members who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. BH-MCO employees who receive telephone complaints and grievances should also be made aware of the speech limitation of some members with disabilities so they can treat these individuals with patience, understanding, and respect.

16. The BH-MCO must provide members with disabilities assistance in presenting their case at complaint or grievance reviews at no cost to the member. This includes:

   a. Providing qualified sign language interpreters for members who are severely hearing impaired;

   b. Providing information submitted on behalf of the BH-MCO at the complaint or grievance review in an alternative format accessible to the member filing the complaint or grievance. The alternative format version should be supplied to the member at or before the review, so the member can discuss and/or refute the content during the review; and
c. Providing personal assistance to members with other physical limitations in copying and presenting documents and other evidence.

17. The BH-MCO must provide language interpreter services when requested by a member at no cost to the member.

18. The BH-MCO must offer members the assistance of a BH-MCO staff member throughout the complaint and grievance process. The BH-MCO staff member cannot have had previous involvement with the issue in dispute.

19. The BH-MCO must ensure that anyone who participates in making the decision on a complaint or grievance was not involved in any previous level of review or decision-making.

20. The BH-MCO must notify the member when the BH-MCO fails to decide a 1st level complaint or 1st level grievance within the timeframes specified in this Appendix, using the template supplied by the Department as Attachment 1a of this Appendix. This notice must be mailed on the date the timeframe for making a decision on the 1st level complaint or 1st level grievance expire.

21. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, using the template supplied by the Department as Attachment 1b of this Appendix. The notice must be mailed to the member on the day that the decision is made to deny payment.

22. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the service provided is not a covered benefit, using the template supplied by the Department as Attachment 1c of this Appendix. The notice must be mailed to the member on the day that the decision is made to deny payment.

23. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the BH-MCO determined that the service(s) was not medically necessary, using the template supplied by the Department Attachment 1d of this Appendix. This notice must be mailed to the member on the day the decision is made to deny payment.

B. Complaint Requirements
Complaint: A dispute or objection filed with the BH-MCO regarding a participating health care provider or the coverage, operations, or management policies of a BH-MCO, including but not limited to: 1) a denial because the requested service is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a complaint or grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit.

The term does not include a grievance.

1. First Level Complaint Process

a. A BH-MCO must permit a member or member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, to file a complaint either orally or in writing. An oral complaint filed about the following:
   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service(s) has been delivered because the service is not a covered benefit.

must be committed to writing by the BH-MCO and must be provided to the member for signature. The signature may be obtained at any point in the process, and failure to obtain a signed complaint may not delay the complaint process.

b. If the complaint is about the following:
   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service(s) has been delivered because the
service is not a covered benefit.

the member must file the complaint within 45 days from the date of the incident complained of or the date the member receives written notice of the decision. For all other complaints, there is no time limit for filing a complaint.

c. If a member files a complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint, if the complaint is hand delivered or post-marked within ten days from the date on the written notice of decision.

d. Upon receipt of the complaint, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 2a of this Appendix or, if the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit

using the template supplied by the Department as Attachment 2b of this Appendix.

e. The first level complaint review for complaints not involving a clinical issue must be performed by a first level complaint review committee, which must include one or more employees of the BH-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the complaint.

f. The first level complaint review for complaints involving a clinical issue must be performed by a first level complaint review committee, which must include one or more employees of the BH-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the complaint. At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision
as described in Appendix AA; section C.3, who must decide the complaint.

g. If the complaint is about the following:
   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit

   the member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member’s attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the first level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the first level complaint review committee.

h. The first level complaint review committee must complete its review of the complaint as expeditiously as the member’s health condition requires, but no more than 30 days from receipt of the complaint, which may be extended by 14 days at the request of the member.

i. The first level complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the complaint record.

j. The BH-MCO must send a written notice of the first level complaint decision to the member, member’s representative, if the member has designated one, service provider and the prescribing provider, if applicable, within five business days of the first level complaint review committee’s decision, using the template supplied by the Department as Attachment 3a of this Appendix or, if the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service has been delivered because the service is not a covered benefit using the template supplied by the Department as Attachment 3b of this Appendix.

k. If the complaint is about the following:
   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit

the member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s first level complaint decision.

2. Second Level Complaint Process

a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for a second level complaint review (“second level complaint”), within 45 days from the date the member receives written notice of the BH-MCO’s first level complaint decision.

b. Upon receipt of the second level complaint, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 4 of this Appendix.

c. If a member files a second level complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the second level complaint, if the second level complaint is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s first level complaint decision.

d. The second level complaint review must be performed by a second level complaint review committee made up of three or more individuals who were not involved in any previous level of review or decision making on the matter.
under review.

e. At least one third of the committee members must be enrolled in the BH-MCO

   (1) If the complaint involves a service for an adult, the consumer member(s) on the second level complaint review committee must be an adult who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.

   (2) If the complaint involves a service for a child or adolescent, the consumer member(s) on the second level complaint review committee must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.

f. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review any information introduced at the meeting.

g. The member must be provided the opportunity to appear before the second level complaint review committee. The BH-MCO must be flexible when scheduling the second level complaint review to facilitate the member’s attendance. The member must be given at least 15 days advance written notice of the review date. The review must be conducted at a time and place convenient to the member. If the member cannot appear in person at the second level complaint review, an opportunity to communicate with the second level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the second level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the second level complaint review committee.

h. The decision of the committee must be based solely on the information presented at the second level complaint review committee meeting.

i. Testimony taken by the second level complaint review committee (including the member’s comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the complaint record.

j. The second level complaint review committee must complete the second level complaint review within 30 days from the BH-MCO’s receipt of the
The BH-MCO must send a written notice of the second level complaint decision to the member, member’s representative, if the member has designated one, service provider and prescribing provider, if applicable, within five business days of the second level complaint review committee’s decision using the template supplied by the Department as Attachment 5a of this Appendix or, if the complaint is about the following:

i. a denial because the requested service is not a covered benefit, or
ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service has been delivered because the service is not a covered benefit

using the template supplied by the Department as Attachment 5b of this Appendix.

If the complaint is about the following:

i. a denial because the requested service is not a covered benefit, or
ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service has been delivered because the service is not a covered benefit

the member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s second level complaint decision.

3. **External Review of Second Level Complaint Review Decision**

   a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for an external review of the second level complaint decision with either the Department of Health or the Insurance Department within 15 days from the date the member receives the written notice of the BH-MCO’s
second level complaint decision.

b. If a member files a request for an external review of a second level complaint decision to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s second level complaint decision.

c. Upon the request of either the Department of Health or the Insurance Department, all records from the first level review and second level review must be transmitted to the appropriate department by the BH-MCO within 30 days from the request in the manner prescribed by that department. The member, the health care provider or the BH-MCO may submit additional materials related to the complaint.

d. The Department of Health and the Insurance Department will determine the appropriate agency for the review.

4. Expedited Complaint Process

a. The BH-MCO must conduct expedited review of a complaint at any point prior to the second level complaint decision, if a member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, provides the BH-MCO with a certification from his or her provider that the member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process. This certification is necessary even when the member’s request for the expedited complaint is made orally. The certification must include the provider’s signature.

b. A request for an expedited review of a complaint may be filed either in writing or orally. Oral requests must be committed to writing by the BH-MCO. The member’s signature is not required.

c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the provider certification is not included with the request for an expedited review, the BH-MCO must inform the member that the provider must submit a certification as to the reason why the expedited review is needed. The BH-
MCO must make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the member’s request for an expedited review, the BH-MCO shall decide the complaint within the standard timeframes as set forth in this Appendix. The BH-MCO must make a reasonable effort to give the member prompt oral notice that the complaint is to be decided within the standard timeframe, and must send written notice within two days of the decision to deny expedited review, using the template supplied by the Department as Attachment 5c of this Appendix.

e. If a member files a request for expedited review of a complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint, if the request for expedited review is hand delivered or post-marked within ten days from the date on the written notice of decision.

f. Complaints requiring expedited review must be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3 and who has not been involved in any previous level of review or decision making on the issue under review.

g. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member’s representative, if the member has designated one, and the member’s provider within either 48 hours from receiving the provider’s certification or three business days from receiving the member’s request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member, the member’s representative, if the member has designated one, and the member’s provider within two days of the decision using the template supplied by the Department (Attachment 6).

h. A summary of the issues presented and decisions made must be maintained as part of the complaint record.

i. The member or the member’s representative, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for an expedited external complaint review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO’s expedited complaint decision.

j. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external reviews.
k. The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s expedited complaint decision.

l. The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution of a complaint or supports a member’s request for an expedited review of a complaint.

C. Grievance Requirements

**Grievance:** A request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or in part, payment for a service if based on lack of medical necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service. The term does not include a complaint.

1. First Level Grievance Process

a. The BH-MCO must permit a member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, to file a grievance either orally or in writing. Oral requests must be committed to writing by the BH-MCO and must be provided to the member for signature. The member’s signature may be obtained at any point in the process, and failure to obtain a signed grievance may not delay the grievance process. The member will be given 45 days from the date the written notice was received to file a grievance.

b. In order for the provider to represent the member in the filing of a grievance, the provider must obtain the written consent of the member. A provider may obtain the member’s written permission at the time of treatment. A provider may NOT require a member to sign a document authorizing the provider to file a grievance as a condition of treatment. The written consent must include:

1. The name and address of the member, the member’s date of birth and identification number,

2. If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signed the consent,

3. The name, address and plan identification number of the provider to whom the member is providing consent,

4. The name and address of the plan to which the grievance will be submitted,
(5) An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent will apply, and

(6) The following statement: “The member or the member’s representative may not submit a grievance concerning the services listed in this consent form unless the member or the member’s representative rescinds consent in writing. The member or member’s representative has the right to rescind consent at any time during the grievance process.”

c. A member who files a grievance to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the grievance is hand delivered or post-marked within ten days from the date on the written notice of decision.

d. Upon receipt of the grievance, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 7 of this Appendix.

e. The first level grievance review must be performed by the first level grievance review committee, which must include one or more employees of the BH-MCO who was not involved in any previous level of review or decision making on the subject of the grievance. At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3, and this individual must decide the grievance.

f. The member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member’s attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level grievance review committee by telephone or videoconference must be provided. The member may elect not to attend the first level grievance meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position at the first level grievance review.

g. The first level grievance review committee must complete its review of the grievance and make a decision as expeditiously as the member’s health condition requires, but no more than 30 days from receipt of the grievance, which may be extended by up to 14 days at the request of the member.
h. The first level grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the grievance record.

i. The BH-MCO must send a written notice of the first level grievance decision, using the template supplied by the Department as Attachment 8 of this Appendix, to the member, member’s representative, if the member has designated one, service provider and prescribing provider, if applicable, within five business days from the first level grievance review committee’s decision.

j. The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s first level grievance decision.

2. Second Level Grievance Process

a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for a second level grievance within 45 days from the date the member receives the written notice of the BH-MCO’s first level grievance decision.

b. Upon receipt of the second level grievance, the BH-MCO must send the member and the member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 9 of this Appendix.

c. A member who files a second level grievance to dispute a decision to discontinue, reduce, or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the second level grievance, if the second level grievance is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s first level grievance decision.

d. The second level grievance review must be performed by a second level grievance review committee made up of three or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the requested service(s). At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3.

e. At least one third of the committee members must be enrolled in the BH-MCO

(1) If the grievance involves a service for an adult, the consumer member(s) on the second level grievance review committee must be an adult who has received or is currently receiving services (mental
health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

(2) If the grievance involves a service for a child or adolescent, the consumer member(s) on the second level grievance review committee must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

f. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review any information introduced at the meeting.

g. The member must be provided the opportunity to appear before the second level grievance review committee. The BH-MCO must be flexible when scheduling the second level review to facilitate the member’s attendance. The committee meeting must be conducted at a time and place convenient to the member. The member must be given at least 15 days advance written notice of the review date. If the member cannot appear in person at the second level review, an opportunity to communicate with the second level grievance review committee by telephone or videoconference must be provided. The member may elect not to attend the second level grievance meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the committee.

h. The BH-MCO will provide the member with a listing of advocate organizations available to assist the member.

i. The second level grievance review committee must complete the second level grievance review and reach a decision within 30 days from receipt of the member’s second level grievance.

j. The decision of the committee must be based solely on the information presented at the second level grievance review committee meeting.

k. Testimony taken by the second level grievance review committee (including the member’s comments) must be either tape recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the grievance record.

l. The BH-MCO must send a written notice of its decision, using the template supplied by the Department as Attachment 10a of this Appendix, to the member, member’s representative, if the member has designated one, service
provider and prescribing provider, if applicable, within five business days of the second level grievance review committee’s decision.

m. The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s second level grievance decision.

3. **External Review of the Second Level Grievance Decision:**

a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request with the BH-MCO for an external review of the second level grievance decision (“external grievance review”) by the Department of Health. The request must be filed orally or in writing within 15 days from the date the member receives the written notice of the BH-MCO’s second level grievance decision.

b. All requests for external grievance reviews are processed through the BH-MCO. The BH-MCO must follow the protocols established by the Department of Health in meeting all timeframes and requirements necessary in coordinating the request and notification of the decision to the member, member’s representative, if the member has designated one, service provider and prescribing provider.

c. A member who files a request for external grievance review to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external grievance review, if the request for external grievance review is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s second level grievance decision.

d. Within five business days of receipt of the request for an external grievance review, the BH-MCO must notify the member, the member’s representative, if the member has designated one, or the health care provider, and the Department of Health that the request for an external grievance review has been filed.

e. The external grievance review must be conducted by an independent utilization review entity not directly affiliated with the BH-MCO.

f. Within two business days from receipt of the request for external grievance review, the Department of Health will randomly assign a certified utilization review entity (CRE) to conduct the review. The BH-MCO and assigned CRE will be notified of this decision.

g. If the Department of Health fails to select a CRE within two business days of
receipt of a request for an external grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its affiliates or is otherwise affiliated with the BH-MCO or its affiliates.

h. The BH-MCO must forward all documentation regarding the decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision, to the CRE conducting the external grievance review. This transmission of information must take place within 15 days from receipt of the request for an external grievance review.

i. The BH-MCO must inform the member that within 15 days from receipt of the request for an external grievance review by the BH-MCO, the member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization, may supply additional information to the CRE conducting the external review for consideration. Copies must also be provided at the same time to the BH-MCO so that the BH-MCO has an opportunity to consider the additional information.

j. Within 60 days from the filing of the request for the external grievance review, the CRE conducting the external grievance review must issue a written decision to the BH-MCO, the member, the member’s representative and the provider (if the provider filed the grievance with the member’s consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.

k. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within 60 days from the date the member receives notice of the external grievance decision.

4. Expedited Grievance Process

a. The BH-MCO must conduct expedited review of a grievance at any point prior to the second level grievance decision, if a member or the member’s representative, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, provides the BH-MCO with a certification from his or her provider that the member’s life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process. This certification is necessary even when the member’s request for the expedited complaint is made orally. The certification must include the provider’s signature.

b. A request for expedited review of a grievance may be filed either in writing
or orally. Oral requests must be committed to writing by the BH-MCO. The member’s signature is not required.

c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the provider certification is not included with the request for an expedited grievance review, the BH-MCO must inform the member that the provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the member’s request for an expedited review, the BH-MCO shall decide the grievance within the standard timeframes as set forth in this Appendix. The BH-MCO must make a reasonable effort to give the member prompt oral notice that the grievance is to be decided within the standard timeframe, and must send written notice within two days of the decision to deny expedited review, using the template supplied by the Department as Attachment 10b of this Appendix.

e. A member who files a request for expedited review of a grievance to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the request for expedited review of a grievance is hand delivered or post-marked within ten days from the date on the written notice of decision.

f. The expedited review process is bound by the same rules and procedures as the second level grievance review process with the exception of time frames, which are modified as specified in this section.

g. Grievances requiring expedited review must be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3 and who was not involved in any previous level of review or decision making on the subject of the grievance.

h. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member’s representative, if the member has designated one, and the member’s provider within either 48 hours from receiving the provider’s certification, or three business days from receiving the member’s request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member, the member’s representative, if the member has designated one, and the member’s provider within two days of the decision using the template supplied by the Department as Attachment 11 of this Appendix.
i. The member or the member’s representative, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for an expedited external grievance review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO’s expedited grievance decision.

j. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s expedited grievance decision.

l. The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution of a grievance or supports a member’s request for expedited review of a grievance.

D. Department’s Fair Hearing Requirements

1. Department’s Fair Hearing Process

   a. A member does not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.

   b. A member or the member’s representative may request a fair hearing within 30 days from the date on the initial written notice of decision and within 30 days from the date on the written notice of the BH-MCO’s first or second level complaint or grievance notice of decision, for any of the following:

      i) the denial, in whole or in part, of payment for a requested service if based on lack of medical necessity;

      ii) the denial of a requested service on the basis that the service is not a covered benefit;

      iii) the denial or issuance of a limited authorization of a requested service, including the type or level of service;

      iv) the reduction, suspension, or termination or a previously authorized service;

      v) the denial of a requested service but approval of an alternative service;

      vi) the failure to provide services in a timely manner, as defined by the Department;
vii) the failure of the BH-MCO to decide a complaint or grievance within the timeframes specified in this Appendix;

viii) a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.

ix) a denial of payment after a service has been delivered because the service is not a covered benefit.

c. The request for a fair hearing must include a copy of the written notice of decision that is the subject of the request. Requests should be sent to:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievance and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

d. A member who files a request for a fair hearing to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for a fair hearing is hand delivered or post-marked within ten days from the date on the written notice of decision.

e. Upon the receipt of the request for a fair hearing, the Department’s Bureau of Hearings and Appeals or a designee will schedule a hearing. The member and the BH-MCO will receive notification of the hearing date by letter at least ten days in advance, or a shorter time if requested by the member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

f. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department’s decision is based solely on the evidence presented at the hearing.

g. The BH-MCO must provide members, at no cost, with records, reports, and documents relevant to the subject of the fair hearing.

h. If the Bureau of Hearings and Appeals has not taken final administrative action within 90 days of the receipt of the request for a fair hearing, the BH-MCO shall follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the member. When the member is responsible for delaying the hearing process the time
limit for final administrative action will be extended by the length of the delay attributed to the member (55 Pa. Code 275.4).

i. The Bureau of Hearings and Appeals’ adjudication is binding on the BH-MCO unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the member may appeal to Commonwealth Court within 30 days from the date of adjudication (or from the Secretary’s final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the BH-MCO.

2. Expedited Fair Hearing Process

a. A request for an expedited fair hearing may be filed with the Department by a member or the member’s representative, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, either orally or in writing.

b. A member does not have to exhaust the complaint or grievance process prior to filing a request for an expedited fair hearing.

c. An expedited fair hearing will be conducted if a member or a member’s representative provides the Department with written certification from the member’s provider that the member’s life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular fair hearing process. This certification is necessary even when the member’s request for the expedited fair hearing is made orally. The certification must include the provider’s signature.

d. A member who files a request for an expedited fair hearing to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for an expedited fair hearing is hand delivered or post-marked within ten days from the date on the written notice of decision.

e. Upon the receipt of the request for an expedited fair hearing, the Department’s Bureau of Hearings and Appeals or a designee will schedule a hearing.

f. The BH-MCO is a party to the hearing and must participate in the hearing. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the BH-MCO to participate in the hearing will not be reason to postpone the hearing.

g. The BH-MCO must provide members, at no cost, with records, reports, and documents, relevant to the subject of the fair hearing.
h. The Bureau of Hearings and Appeals has 3 business days from the receipt of the member’s oral or written request for an expedited review to process final administrative action.

i. The Bureau of Hearings and Appeals’ adjudication is binding on the BH-MCO unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the member may appeal to Commonwealth Court within 30 days from the date of adjudication (or from the Secretary’s final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the BH-MCO.

E. Provision of and Payment for Services Following Decision

1. If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services that were not furnished during the complaint, grievance or fair hearing process, the BH-MCO must authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires.

2. If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services, and the member received the disputed services during the complaint, grievance or fair hearing process, the BH-MCO must pay for those services.
Notice for Failure of MCO to Meet Complaint or Grievance Time Frames

[Date Notice Mailed (1 day after the date the decision was to be made)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your [Complaint][Grievance] About [Issue].

Dear [Member Name]:

[MCO Name] has not decided your [complaint][grievance] about [identify subject of complaint/grievance], filed on [date], within [number that is fewer than 30 days] days, as required. We expect to be able to decide the [complaint][grievance] by [date].

If you are unhappy that [MCO name] has not decided your [complaint/grievance] within [#] days of receiving it, you can do one or both of the following:

1) File a Complaint

You may file a complaint with [MCO Name] about the delay in deciding your [complaint][grievance]. You must file the complaint within 45 days from the date you get this notice. A decision will be made on your complaint no later than [30, unless the MCO will be using a shorter time frame to decide first level complaints] days from when we receive it.

To file a complaint:

- Call [MCO Name] at [#]; or
- Send your complaint to [MCO Name] at the following address:

[MCO Address for filing complaint]
2) **Request a Fair Hearing**

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]  
[Provider, if BBA Complaint or grievance]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint][grievance] you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear [Member Name]:

[MCO Name] has reviewed the request for payment from [provider’s name] for [identify specific service], which you received on [date]. Your provider’s request for payment has been denied because [provider’s name] is not enrolled in the Pennsylvania Medical Assistance Program and did not ask [MCO Name] for approval to provide the service to you.

[PROVIDER’S NAME] MAY BILL YOU FOR THIS SERVICE.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) File a Complaint

You may file a complaint with [MCO name] within 45 days from the date you get this notice. A decision will be made on your complaint no later than [30, unless the MCO will be using a shorter time frame to decide first level complaints] days from when we receive it.

To file a complaint:

- Call [MCO Name] at [#]; or
- Send your complaint to [MCO Name] at the following address:

    [MCO Address for filing complaint]
2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health & Substance Abuse Services  
Division of Grievance & Appeals  
Beechmont Bldg. #32, Second floor  
P.O. Box 2675  
Harrisburg, Pennsylvania, 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

You may appear in person or by telephone at both the complaint review and the fair hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a fair hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[Address for records information]

If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Provider]
[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 1c
Notice for Payment Denial Because the Service Was Not a Covered Service for the Member

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear [Member Name]:

[MCO Name] has reviewed the request for payment from [provider’s name] for [identify specific service], which you received on [date]. Your provider’s request for payment has been denied. The service you received is not a covered benefit because:

________ It is not covered under the Medical Assistance Program; OR

________ It is not part of your benefit package; OR

________ [Provider’s name] is not in [MCO Name’s] provider network and provided this service without [MCO Name’s] authorization.

[PROVIDER’S NAME] MAY BILL YOU FOR THIS SERVICE ONLY IF [PROVIDER’S NAME] TOLD YOU THAT THE SERVICE WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) File a Complaint

You may file a complaint with [MCO Name] within 45 days from the date you get this notice. A decision will be made on your complaint no later than [30, unless the MCO will be using a shorter time frame to decide first level complaints] days from when we receive it.
To file a complaint:

- Call [MCO Name] at [#]; or
- Send your complaint to [MCO Name] at the following address:

[MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health & Substance Abuse Services  
Division of Grievance & Appeals  
Beechmont Bldg. #32, Second floor  
P.O. Box 2675  
Harrisburg, Pennsylvania, 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request. (see your member handbook for more details).

You may appear in person or by telephone at both the complaint review and the fair hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a fair hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[Address for records information]
If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 1d
Notice for Denial of Payment After a Service(s) Has Been Delivered
Because the Emergency Room Service(s) Was Not Medically Necessary

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: **********

Dear [Member Name]:

[MCO Name] has reviewed the request for payment from [provider's name] for [identify specific service], which you received on [date]. Your provider's request for payment has been denied.

The service you received was not medically necessary because:

[Explain in detail every reason for denial; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

[PROVIDER’S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER’S NAME] IF [PROVIDER’S NAME] SENDS YOU A BILL.

Sincerely,

[MCO Name]

cc: [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 2a

First Level Complaint Acknowledgment Letter

MCO: Use this template for all complaints EXCEPT for those involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Complaint About [Complaint Issue].

Dear [Member Name]:

[MCO Name] received your complaint about [identify subject of complaint] on [date of receipt].

The First Level Complaint Process

A committee of one or more [MCO Name] staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by [date that is no more than 30 days from receipt of the complaint]. This is called the “complaint review.” A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If
you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see all information relevant to your complaint. You may also send information that you have about your complaint to [MCO Name]:

[MCO Address]

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

   Pennsylvania Department of Health
   Bureau of Managed Care
   Room 912 Health & Welfare Building
   625 Forster Street
   Harrisburg, PA 17108
   Telephone: 1-888-466-2787; Fax: 1-717-705-0947
   AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a grievance is, you can read your member handbook or call us at [MCO Phone #].

To get help with your complaint

- If you need help with your complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]
The information in this letter is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 2b
First Level Complaint Acknowledgment Letter

MCO: Use this template ONLY for complaints involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Complaint About [Complaint Issue].

Dear [Member Name]:

On [date of complaint] [MCO Name] received your complaint that:

_____ you have not received your [type of services] in the time you should have received them, or

_____ you did not receive a decision on your complaint or grievance in the time you should have received it, or

_____ you disagree with the decision to deny a service because the requested service is not a covered benefit, or

_____ you disagree with the decision to deny payment to your provider because your provider is not enrolled in the Pennsylvania Medical Assistance Program and did not receive authorization to provide the service to you, or

_____ you disagree with the decision to deny payment to your provider because the service you received is not a covered benefit.
The First Level Complaint Process

A committee of one or more [MCO Name] staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by [date that is no more than 30 days from receipt of the complaint]. This is called the “complaint review.” A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see any information relevant to your complaint. You may also send information that you have about your complaint to [MCO Name]:

[MCO Address]

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17108
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this letter. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

To ask for an early decision

If your doctor or psychologist believes that waiting [30, unless the MCO will be using a shorter time frame to decide first level complaints] days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call [MCO Name] at [#];
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [30, unless the MCO will be using a shorter time frame]
to decide first level complaints] days to decide your complaint could harm your health.

[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or psychologist's letter, or within 3 business days from when we receive your request, whichever is sooner.

The Fair Hearing Process

At any point before [MCO Name] makes its decision, you may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this letter**. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this letter;
- A copy of the original denial notice, if available. [MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
• Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

• If you need help with your complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
• If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you made with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
MCO, Use this template for all complaints EXCEPT for those involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Notice Mailed (no more than 5 business days after the first level complaint decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Decision About Your Complaint

Dear [Member Name]:

[MCO Name] has reviewed your complaint about [issue], received on [date].

Based on a review of all information provided, the first level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].
IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[MCO Address]

2) File a Second Level Complaint

You may file a second level complaint with [MCO Name] within 45 days from the date you get this notice. A decision will be made on your second level complaint no later than [30, unless the MCO will be using a shorter time frame to decide second level complaints] days from when we receive it.

To file a second level complaint:

- Call [MCO Name] at [#]; or
- Send your complaint to [MCO Name] at the following address:

[MCO Address for filing complaint]

To get help with a complaint

- If you need help filing a second level complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 3b

First Level Complaint Decision Notice

MCO, Use this template ONLY for complaints involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Notice Mailed (no more than 5 business days after the first level complaint decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Decision About Your Complaint

Dear [Member Name]:

[MCO Name] has reviewed your complaint about [issue], received on [date].

Based on a review of all information provided, the first level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]
To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level complaint, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[MCO Address]

2) File a Second Level Complaint

You may file a second level complaint with [MCO Name] within 45 days from the date you get this notice. A decision will be made on your second level complaint no later than [30, unless the MCO will be using a shorter time frame to decide second level complaints] days from when we receive it.

To file a second level complaint:

• Call [MCO Name] at [#]; or
• Send your complaint to [MCO Name] at the following address:

[MCO Address for filing complaint]

To ask for an early decision

If your doctor or psychologist believes that waiting [30, unless the MCO will be using a shorter time frame to decide second level complaints] days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

• Call [MCO Name] at [#];
• Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [30 unless the MCO will be using a shorter time frame to decide second level complaints] days to decide your complaint could harm your health.
[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter or within 3 business days from when we receive your request, whichever is sooner.

3) **Request a Fair Hearing**

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;

- A copy of the original denial notice, if available. **[MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or
psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a complaint or request for fair hearing

- If you need help filing a second level complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.

- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated] [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
Second Level Complaint Acknowledgment Letter

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Second Level Complaint About [Complaint Issue]

Dear [Member Name]:

[MCO Name] received your second level complaint about [identify subject of complaint] on [date of receipt].

The Second Level Complaint Process

A committee of three or more people, including at least one person who is a [MCO Name] member, will make a decision about your complaint by [date that is no more than 30 days from receipt of the complaint]. This is called the “complaint review.” No one on the committee will have been involved in the complaint issue. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see any information relevant to your complaint. You may also send information that you have about your complaint to [MCO Name]:

[MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this letter. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the complaint review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.
To get help with your complaint

- If you need help with your complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
**ATTACHMENT 5a**

Second Level Complaint Decision Notice

MCO, Use this template for all complaints EXCEPT for those involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Notice Mailed (no more than 5 business days after second level complaint decision)]

Member Name  
Address  
City, State Zip  

Member ID: ********

Subject: Decision About Your Second Level Complaint

Dear [Member Name]:

[MCO Name] has reviewed your second level complaint about [issue], received on [date].

Based on a review of all information provided, the second level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].
IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[MCO Address]

2) Request an External Review

You may ask for an “external review” of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department within 15 days from the date you get this notice.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17108
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the member’s) name, address, and daytime telephone number;
- Your (the member’s) [MCO Name] identification number;
- [MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.
To get help with a request for external review

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
Second Level Complaint Decision Notice

MCO, Use this template ONLY for complaints involving the following:

1. A denial because the requested service is not a covered benefit.
2. Failure of the MCO to meet the required time frames for providing a service.
3. Failure of the MCO to decide a complaint or a grievance within the specified time frames.
4. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.
5. A denial of payment after a service has been delivered because the service is not a covered benefit.

[Date Notice Mailed (no more than 5 business days after the second level complaint decision)]

Member Name
Address
City, State Zip
Member ID: ********

Subject: Decision About Your Second Level Complaint

Dear [Member Name]:

[MCO Name] has reviewed your second level complaint about [issue], received on [date].

Based on a review of all information provided, the second level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]
To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[MCO Address]

2) Request an External Review

You may ask for an “external review” of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department within 15 days from the date you get this notice.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17108
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388
Your request for external review by either Department must include the following information:

- Your (the member’s) name, address, and daytime telephone number;
- Your (the member’s) [MCO Name] identification number;
- [MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. [MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.
To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
[Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 5c

Notice of Failure to Receive Provider Certification for an Expedited Complaint

[Date Notice Mailed (no more than 2 days after date of decision to deny expedited review)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Request for "Expedited" Complaint

Dear [Member Name]:

[MCO Name] received your complaint about [identify subject of complaint], on [date] and your request to have the complaint decided more quickly than the usual [30, unless the MCO will be using a shorter time frame to decide first level complaints]-day time frame. As we told you when you filed your complaint, in order for your complaint to be decided more quickly, your [doctor][psychologist] needed to send us a written statement that taking the usual amount of time to decide the complaint could harm your health. [MCO Name] also asked your [doctor][psychologist] for this statement.

We have not received your [doctor’s][psychologist’s] statement, so your complaint will be decided within the usual time frame of [30, unless the MCO will be using a shorter time frame to decide first level complaints] days from when we first got your complaint.

The First Level Complaint Process

A committee of one or more [MCO Name] staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by [date that is no more than 30 days from receipt of the complaint]. This is called the “complaint review.” A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.
You or your representative may ask [MCO Name] to see all information relevant to your complaint. You may also send information that you have about your complaint to [MCO Name]:

[MCO Address]

[MCO: Include the following paragraphs on the complaint review, Fair Hearings, and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services in a timely manner; failure to decide a complaint or grievance within 30 days; denial of service as not a covered benefit (whether prior authorization or payment denial); or denial because the service was provided without authorization by a non-MA provider.]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available [MCO: Include this last item for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675
The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

- If you need help with your complaint, call us at [MCO Phone #], and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
[Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
Expediting Complaint Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: “Expeditied” Decision About Your Complaint

Dear [Member Name]:

[MCO Name] has reviewed your complaint about [issue], received on [date].

Based on a review of all information provided, the review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]

To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level complaint or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:
1) **Request Guidelines**

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[MCO Address]

2) **Request an Expedited External Review**

You may ask for an “expedited external review” of the complaint decision from the Pennsylvania Department of Health. You may ask for the external review within two business days from the date you get this notice. A decision will be issued within five business days from when we receive your request.

To file an expedited external review:

- Call [MCO Name] at [MCO Phone #]; or
- Fax [MCO Name] at [MCO Fax #]; or
- Send your request to [MCO Name] at the following address:

[MCO Address for requesting external review]

3) **Request a Fair Hearing**

**To ask for an early decision**

You may ask for a fair hearing from the Department of Public Welfare. If your doctor or psychologist still believes that the usual time frame for deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.
Even if you no longer need an early decision, you may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice.**

Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. [MCO: Include this last item only for complaints challenging a denial because the service is not a covered benefit.]

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675  

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

**To get help with a request for external review or fair hearing**

- If you need help filling a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]  
[Provider]
[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 7

First Level Grievance Acknowledgment Letter

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Grievance About [Grievance Issue]

Dear [Member Name]:

[MCO Name] received your grievance about [identify subject of grievance] on [date of receipt].

The First Level Grievance Process

A committee of one or more [MCO Name] staff members that includes a licensed doctor or licensed psychologist, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the “grievance review.” A decision will be made by [date that is no more than 30 days from receipt of the grievance]. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see all information relevant to your grievance. You may also send information that you have about your grievance to [MCO Name]:

[MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this letter. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.
If you think your issue is really a complaint and should not be treated as a grievance, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17108
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a complaint is, you can read your member handbook or call us at [MCO Phone #].

To get help with your grievance

- If you need help with your grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
[Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 8

First Level Grievance Decision Notice

[Date Notice Mailed (no more than 5 business days after the date of the first level grievance decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Decision About Your Grievance

Dear [Member Name]:

[MCO Name] has reviewed your grievance about [issue], received on [date].

Based on a review of all information provided, the first level grievance review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level grievance or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:
1) **Request Criteria**

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[MCO Address]

2) **File a Second Level Grievance**

You may file a second level grievance with [MCO Name] **within 45 days from the date you get this notice**. A decision will be made on your second level grievance no later than **[30, unless the MCO will be using a shorter time frame to decide second level grievances]** days from when we receive it.

To file a second level grievance:

- Call [MCO Name] at [#]; or
- Send your grievance to [MCO Name] at the following address:

[MCO Address for filing grievance]

 **To ask for an early decision**

If your doctor or psychologist believes that waiting **[30, unless the MCO will be using a shorter time frame to decide second level grievances]** days to get a decision could harm your health, you may ask that your grievance be decided more quickly. To do this:

- Call [MCO Name] at [#];
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking **[30 unless the MCO will be using a shorter time frame to decide second level grievances]** days to decide your grievance could harm your health.

[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter or within 3 business days from when we receive your request, whichever is sooner.

3) **Request a Fair Hearing**

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:
● Your (the member’s) name, social security number, and date of birth;
● A telephone number where you can be reached during the day;
● Whether you want to have a hearing in person or by telephone;
● The reason(s) you are asking for a fair hearing, or a copy of this notice;
● A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

● Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
● Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

To get help with a grievance or request for fair hearing

● If you need help filing a second level grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
● If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
Sincerely,

[MCO Name]

cc: [Member Representative, if designated]  
    [Provider]

[MCO, the following statement must appear in English, Russian,  
Cambodian, Vietnamese, Spanish, Chinese, and any other language as  
required by the contract:]

The information in this notice is about the grievance you filed with [MCO  
Name]. It is available in other languages and formats by calling [MCO  
Name] at [#].
ATTACHMENT 9

Second Level Grievance Acknowledgment Letter

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Second Level Grievance About [Grievance Issue]

Dear [Member Name]:

[MCO Name] received your second level grievance about [identify subject of grievance] on [date of receipt].

The Second Level Grievance Process

A committee of three or more people, which includes a licensed doctor or licensed psychologist, and at least one [MCO Name] member, will review your grievance. This is called the “grievance review.” No one on the committee will have been involved in the grievance issue. A decision will be made by [date that is no more than 30 days from receipt of the grievance]. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see any information relevant to your grievance. You may also send information that you have about your grievance to [MCO Name]:

[MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this letter. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the grievance review, telling you the place, date
and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

**To get help with your grievance**

- If you need help with your grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
    [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 10a

Second Level Grievance Decision Notice

[Date Notice Mailed (no more than 5 business days after the date of the second level grievance decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Grievance

Dear [Member Name]:

[MCO Name] has reviewed your second level grievance about [issue], received on [date].

Based on a review of all information provided, the second level grievance review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:
1) Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[MCO Address]

2) Request an External Review

You may ask for an “external review” of the second level grievance decision within 15 days from the date on this notice. An external review is a review by a licensed doctor who does not work for [MCO Name].

Your request for an external review must be sent to the following address:

[MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.
To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
    [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 10b

Notice of Failure to Receive Provider Certification for an Expedited Grievance

[Date Notice Mailed (no more than 2 days after date of decision to deny expedited review)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Request for “Expedited” Grievance

Dear [Member Name]:

[MCO Name] received your grievance about [identify subject of grievance], on [date] and your request to have the grievance decided more quickly than the usual [30, unless the MCO will be using a shorter time frame to decide first level grievances]-day time frame. As we told you when you filed your grievance, in order for your grievance to be decided more quickly, your [doctor][psychologist] needed to send us a written statement that taking the usual amount of time to decide the grievance could harm your health. [MCO Name] also asked your [doctor][psychologist] for this statement.

We have not received your [doctor's][psychologist's] statement, so your grievance will be decided within the usual time frame of [30, unless the MCO will be using a shorter time frame to decide first level grievances] days from when we first got your grievance.

The First Level Grievance Process

A committee of one or more [MCO Name] staff members that includes a licensed doctor or licensed psychologist, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the “grievance review.” A decision will be made by [date that is no more than 30 days from receipt of the grievance]. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.
At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.

You or your representative may ask [MCO Name] to see any information relevant to your grievance. You may also send information that you have about your grievance to [MCO Name]:

[MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

    Department of Public Welfare
    Office of Mental Health and Substance Abuse Services
    Division of Grievances and Appeals
    Beechmont Building #32
    P.O. Box 2675
    Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).
To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your grievance or request for fair hearing

- If you need help with your grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
    [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 11

Expedited Grievance Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: “Expedited” Decision About Your Grievance

Dear [Member Name]:

[MCO Name] has reviewed your grievance about [issue], received on [date].

Based on a review of all information provided, the review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days from the date on this notice, the services will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:
1) Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[MCO Address]

2) Request an Expedited External Review

You may ask for an "expedited" external review of the grievance decision. An external review is a review by a licensed doctor who does not work for [MCO Name]. You must ask for the "external review" within two business days from the date you get this notice. A decision will be issued within five business days from when we receive your request.

To ask for an external review:

- Call [MCO Name] at [MCO Phone #]; or
- Fax [MCO Name] at [MCO Fax #]; or
- Send your request to [MCO Name] at the following address:

[MCO Address for requesting external review]

3) Request a Fair Hearing

To ask for an early decision

You may ask for a fair hearing from the Department of Public Welfare. If your doctor or psychologist still believes that the usual time frame for deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.
Even if you no longer need an early decision, you may ask for a fair hearing from the Department of Public Welfare. The request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

**To get help with a request for external review or fair hearing**

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]
[Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#]
Indicators of the Application of CASSP Principles

The Pennsylvania Child and Adolescent Service System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. The application of these principles is expected at all levels of an organization serving children with mental health needs and within all children’s mental health functions at the state and local levels. Services delivered according to CASSP principles are child-centered, family-focused, community-based, multi-system, culturally competent and least restrictive/least intrusive.

The Department, in its issuance of the Request for Proposals for the HealthChoices Program, requires adherence to both the CASSP and Community Support Program (CSP-Adult) principles by the county managed care organization (MCO), its subcontractors and any associated provider networks.

In order to gain a better understanding of the manner in which CASSP principles are applied in daily operations, the following list of examples is offered as indicators of the application of the six CASSP principles. CASSP principles also provide the understanding for a sound approach to a Quality Assurance Program. Five areas of application within an agency are addressed: environment, policy and procedures, clinical records, data information and financing. The list provided is suggestive, not exhaustive, and the Office of Mental Health and Substance Abuse Services is interested in receiving feedback from the field.

**Child-centered**

**The Principle:**

*Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.*

**The Indicators:**

- Toys, children’s literature, furniture for small children, and adolescent literature are available in the waiting rooms and offices.

- Credentialing criteria reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-
• Assessments include the use of tools that are age- and/or developmentally- appropriate.

• The strengths, interests and resources of the child are identified in assessments, treatment plans and progress notes.

• A treatment plan format with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.

• An adolescent satisfaction survey is included in consumer satisfaction protocols.

• Adolescents are included in interagency team meetings.

• Data elements collected include child and adolescent factors identified in the performance outcome measures (POMs).

• Financial support is given to the training of staff in child and adolescent clinical specialty areas.

**Family-focused**

The Principle:

*Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.*

The Indicators:

• Information for families, including local family support/advocacy organizations, is in the waiting room; for example, the PIN newsletter, *Sharing; CHADD; Right to Education*, etc.

• Parents/guardians participate as team members on treatment teams or any interagency meetings, or records include documentation of efforts to include them.

• Parents/guardians sign the treatment plan after they have been fully involved in its development.

• Personnel work to ensure that appointments are available in the evenings and on weekends and at times convenient for the family.

• The member handbook, which also includes the grievance and appeals procedures, is written in clear and understandable language.

• Personnel ensure that families get copies of the member handbook and understand who to call for help with questions.
• Consumer satisfaction protocols include items specific for families of children and adolescents.

• Families of children and/or adolescents are involved on the agency/management board or a family/community advisory committee to the agency.

• The member handbook indicates that child and adolescent specialists can be requested by the family to provide treatment services for their child.

**Community-based**

**The Principle:**

*Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.*

**The Indicators:**

* Resources within the zip code or within 10 miles are used.

* Local resource pamphlets — such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs — are located in service management offices.

* Natural resources are used in each treatment plan, such as school, work, leisure and church activities.

* Orientation to and support for public transportation are available to families.

* The data system tracks the use of local/community resources.

* There is a policy/procedure to reach out families and their children when needed.

* The staff training schedule includes topics on community resources and understanding the community in which the staff works.

* If community-based resources are not available for a family, there is an administrative/financial plan to address the service gap.

* Records of community involvement and participation are maintained

**Multi-system**

**The Principle:**

*Services are planned in collaboration with all the child-serving systems involved in the child's life.*
Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

The Indicators:

- Families and, if they choose, an advocate/support person participate in the interagency meeting as members of the team.
- Interagency team meetings are held in a convenient and comfortable room with access to blackboard/newsprint, etc.
- At a minimum, mental health and education personnel are involved in interagency team meetings for children and adolescents who are of school age.
- Child-serving systems and other persons/informal support systems involved with the child are included in the treatment process as documented in telephone calls, conferences and interagency meetings.
- Letters of agreement with each child-serving system are current (for each fiscal year) and include a conflict resolution protocol.
- Procedures are written for convening the interagency team, including when meetings are called, who calls them and who leads them.
- Each child's service plan reflects the contribution of each involved service system.
- The data system reports the cross-system outcome measures as identified in the POMS.
- Individual practitioners/agency/MCO staff are knowledgeable and participate in the county child-serving systems collaborative structure.
- Progress notes reflect a summary of interagency team meetings and attendees, and are distributed to the team.

Culturally competent

The Principle:

Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.
The Indicators:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the minority groups the agency serves.

- Waiting rooms and offices have literature reflecting the ethnic groups in the community.

- The schedule of regular staff training includes cultural competency development, and related topics.

- Introductory cultural competency trainings for staff incorporate the following elements:
  
  a. overview of cultural diversity
  
  b. the principles of cultural competency development
  
  c. conducting psychiatric and psychological assessments applicable to the individual's cultural context
  
  d. treatment planning appropriate to the individual, family, and cultural context
  
  e. integrating community supports and resources
  
  f. considering and using non-traditional methods and services
  
  g. direct service provision and effectively engaging minorities in treatment

- More advanced trainings involve issues and related topics.

- Service delivery reflects:
  
  a. psychiatric assessments which incorporate an appreciation of the child's or adolescent's culture and level of acculturation
  
  b. treatment plans/consultations which involve or reflect the family’s cultural perspective
  
  c. up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
  
  d. recognition of the importance of religion, religious expression and religious institutions
  
  e. services available from clinical staff who speak the language understood by children and families or who use interpreters
  
  f. interagency meetings which welcome extended family members
g. recognition of culturally relevant holidays

h. tracking of completion rate for appointments by ethnicity, age and gender

- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

**Least restrictive/least intrusive**

**The Principle:**

*Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.*

**The Indicators:**

- Family-friendly consolidation in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
- The community integration questionnaire is used to ensure the use of least restrictive services.
- In-home, in-school and in-community resources are safely used first before out-of-home placement is considered.
- Justification for each service or placement considered is documented.
- The family has a voice in the process of identifying appropriate staff for various in-home services.
Indicators of the Application of CSP Principles

The Pennsylvania Community Support Program (CSP) is based on a well-defined set of principles for mental health services for adults with serious mental illness developed in 1977 at the National Institute of Mental Health. Services delivered according to CSP principles are consumer-centered/consumer empowered, culturally competent, flexible, meet special needs, accountable, strengths-based, community-based/natural supports and coordinated. The application of these principles is expected at all levels of an organization serving adults with mental health needs.

The Department, in its issuance of the Request for Proposals for the HealthChoices Program, requires adherence to both the CSP and CASSP (children and adolescent service system program) principles by the county managed care organization (MCO), its subcontractors and any associated provider networks. Adherence to these principles will be monitored by the PA Office of Mental Health, through consumer satisfaction teams and other methods as appropriate.

In order to gain a better understanding of the manner in which the CSP principles are applied in daily operations, the following list of examples is offered as indicators of the application of the eight CSP principles. CSP principles also provide a foundation for the development of a quality assurance program. Five areas of application within an agency are addressed: environment, policy and procedures, clinical records, data information and financing. This list is not exhaustive and, the Office of Mental Health is interested in receiving feedback from the field.

Consumer-centered/Consumer-empowered

The Principle:

Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.

The Indicators:
• Consumers are integrally involved in designing and evaluating services.

• Consumer preferences are honored whenever possible (e.g., therapist/case manager, decor, living arrangements, programming, food selection, etc.).

• Consumer self-help and consumer-run alternatives are promoted and funded.

• Individual strengths, interests and resources are identified in assessments, treatment plans and progress notes.

• Treatment/service plans reflect consumer involvement in goal setting and decisions regarding services. Consumers' signatures appear on all treatment/service plans, or an explanation of why the consumer has not signed is noted.

• Personnel policies encourage the hiring of consumers as staff, consultants, trainers.

• Consumer confidentiality is honored.

• People First language is used in all written materials (e.g., people with schizophrenia not schizophrenics).

• Information is available to consumers on self-help philosophy and statewide and local consumer organizations.

• Data collection reflects outcomes important to consumers (e.g., employment, housing, social supports).

**Culturally Competent**

**The Principle:**

*Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are designed and delivered to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices of an individual or a particular group of people.*

**The Indicators:**

• Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the minority groups the agency serves.

• Waiting room and offices have literature reflecting the ethnic groups in the community.
• The schedule of regular staff training includes cultural competency development, and related topics.

• Introductory cultural competency trainings for staff incorporate the following elements:
  a. overview of cultural diversity
  b. the principles of cultural competency development
  c. conducting psychiatric and psychological assessments applicable to the individual's cultural context
  d. treatment planning appropriate to the individual, family, and cultural context
  e. integrating community supports and resources
  f. considering and using non-traditional methods and services
  g. direct service provision and effectively engaging minorities in treatment

• Service delivery reflects:
  a. psychiatric assessments which incorporate an appreciation of the consumer's culture and level of acculturation
  b. treatment plans/consultations which involve or reflect the family's cultural perspective
  c. up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
  d. recognition of the importance of religion, religious expression and religious institutions
  e. services available from clinical staff who speak the language understood by the consumer or who use interpreters
  f. interagency meetings which welcome extended family members
  g. recognition of culturally relevant holidays
  h. tracking of completion rate for appointments by ethnicity, age and gender

• Administrative and treatment staff represent the cultural diversity of the community the
• Minority members participate at the policy-making and administrative/monitoring levels.
• Advisory boards include minority membership.
• Consumer satisfaction protocols include questions tailored to ethnic communities.

**Flexible**

**The Principle:**

*The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times, and delivered in a wide range of environments.*

**The Indicators:**

• A full array of treatment, rehabilitation and support services are available in accessible locations.
• Day, evening and weekend hours are available.
• Services are delivered at a variety of locations, including the consumer's home or community as appropriate.
• Type and duration of service is based on consumer need.
• Staff credentialing standards recognize expertise in rehabilitative, self-help and alternative treatment approaches.

**Meet Special Needs**

**The Principle:**

*Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, mental retardation, homelessness, HIV/AIDS, and involvement in the criminal justice system.*

**The Indicators:**
• Representatives from other service systems are involved in developing/implementing the treatment/service plan of persons with special needs.

• Staff specialists are available/trained to meet the diverse needs of consumers, as outlined above.

• Timely mobile outreach is provided to specialty populations including persons who are elderly, homeless and involved in the criminal justice system.

• Data systems track service utilization and outcomes specific to special populations.

• TDD telephone access, sign language interpreters, braille materials and other assistive devices are available, as needed.

• Creative interagency agreements and funding focus on the total needs of the individual (cross-training of staff, co-location of staff, etc.).

**Accountable**

**The Principle:**

*Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring and evaluating services.*

**The Indicators:**

• Consumers and families are integrally involved in the design, development and evaluation of services. This includes:
  
  * Consumer satisfaction teams.
  
  * Consumer/family membership on governing/advisory boards.

• Information on services, diagnoses, medications, etc. is available and written in consumer friendly language.

• The member handbook, which also includes the grievance and appeal procedures, is written in clear and understandable language.

• Personnel ensure that consumers receive copies of the member handbook and understand who to call for help with questions.

• Development of positive outcome measures, such as stabilization/growth in functioning, increased consumer satisfaction, etc.
- Balanced focus on cost, quality, outcome and access, when evaluating program success.
- Data and standards related to demographics, budgets/expenditures, criteria for service authorizations, complaints/appeals, outcomes, etc. are provided to consumers/families and advocates for review.

**Strengths-Based**

**The Principle:**

*Services build upon the assets and strengths of consumers to promote growth and movement toward independence.*

**The Indicators:**

- Service interventions promote a wellness, not illness, focus.
- Assessments, treatment/service plans and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
- Written materials support People First language and the role of consumer as a key partner in the recovery process.

**Community-Based/Natural Supports**

**The Principle:**

*Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.*

**The Indicators:**

- Community based resources/services within the zip code or within 10 miles are used.
- Pamphlets/information on local resources and services are made available through administrative entities and provider agencies.
- Training and support in finding and using transportation is available to consumers.
- Natural resources are used in each treatment plan, such as housing, work, leisure and church activities.
• Consumers are encouraged to develop advance directives in preparation for crises for staff/family to follow.

• Individuals identified by the consumer as supports should be incorporated into the treatment/service plan.

• The data system tracks the use of local/community resources.

• There is a policy/procedure to reach out to consumers and their families when needed.

• The staff training schedule includes topics on community resources and understanding the community in which the staff works.

## Coordinated

### The Principle:

*Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.*

### The Indicators:

• Written agreements/plans for coordination are in place with the following:
  - State hospitals.
  - Medical services (HMO's, etc.). This should include a good baseline medical work-up, coordination in monitoring physical and neurobiological services, etc.
  - Social service agencies (Offices of aging, vocational rehabilitation, housing authorities, drug and alcohol programs, homeless shelters, legal services, etc.)
  - Police departments, district justices, jails and prisons, etc.

• Staff are designated as liaisons to other service agencies in order to plan and facilitate services.

• Staff development/training involves overview of service agencies in area (e.g., policies, procedures, mission statement, regulations, etc.).

FIRST EDITION
January 31, 1997
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CASSP Principles

For County Mental Health Programs

Instructions: The Local CASSP Advisory Committee should receive a copy of the Indicators of the Application of the CASSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CASSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CASSP Advisory Committee shall then forward the completed document to the MH/MR Administrator’s Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CASSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole.

   Please indicate a “yes” or “no” response.

2. The second set is applicable to individual agencies. (They can also be found in the HealthChoices Southwest RFP, Appendix I). Please indicate the responses, “All”, “Most”, “Some”, and “Few”, that best describe the presence of the agency indicators in the county programs.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for “no responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened in plan year 2001-2002.
I. Child-centered

The Principle:

*Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child’s family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.*

The Indicators for County Mental Health Program:

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Office staff are courteous, respectful, and willing to assist parents either in person or on the telephone.

CASSP Coordinator position is filled.

CASSP Coordinator has a Master’s Degree or a minimum of 5 years experience with children’s services.

CASSP Coordinator is a discrete position located in an administrative office, has administrative responsibility for children’s services and provides no direct services.

Credentialing criteria for staff overseeing children’s programs reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.

Orientation to CASSP values has become an integrated component for new staff in administrative, supervisory, and direct service positions.

A service plan format for CASSP meetings with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.

Adolescents are included in CASSP meetings.

The county has a Consumer Satisfaction Team and/or Family Satisfaction Team and an adolescent satisfaction survey is included in consumer/family satisfaction protocols.

When conducting program evaluations, data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).

CASSP Coordinator is provided with opportunity for training in child/adolescent issues.
Other county level indicators:

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in assisting children and adolescents with special needs from initial intake, through assessment planning, intervention and after care services, and the communication tool of the child/adolescent’s choice is utilized.

All    Most    Some    Few                  All    Most    Some    Few
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

• Toys, children’s literature, furniture for small children, and adolescent literature are available in the waiting rooms and offices.
• Credentialing criteria reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
• Assessments include the use of tools that are age- and/or developmentally-appropriate.
• The strengths, interests and resources of the child are identified in assessments, treatment plans and progress notes.
• An individualized treatment plan format with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
• An adolescent satisfaction survey is included in consumer satisfaction protocols.
• Adolescents are included in interagency team meetings.
• Data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
• Financial support is given to the training of staff in child and adolescent clinical specialty areas.

Narrative summarizing how the “child-centered” principle will be strengthened in plan year 2001-2002:
II. Family-focused

The Principle: Services recognize that the family is the primary support system for the child. The family participates as full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

The Indicators for County Mental Health Programs:

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When parents act as trainers for professionals, they are paid the same honorarium as professional trainers.

The county funds a family advocate position.

Proposals submitted to state offices for new service initiatives include support letters from parents.

Parent leaders or groups agree that the local CASSP project has addressed their concerns.

Parents are included in program reviews

The county reimburses families for transportation and child-care costs related to participation in county CASSP activities.

**Other county level indicators:**

County staff are familiar with and will provide for and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in involving families/caregivers with special needs to participate in all phases of planning and treatment for their special needs family member. The communication tool of family’s/caregiver’s choice is utilized.

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County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

**The Indicators for Agencies:**

- Information for families, including local family support/advocacy organizations, is in the waiting room; for example, the PIN newsletter, Sharing; CHADD; Right to Education, etc.
- Parents/guardians participate as team members on treatment teams or any interagency meetings, or records include documentation of efforts to include them.
- Parents/guardians sign the treatment plan after they have been fully involved in the development of it.
- Personnel work to ensure that appointments are available in the evenings and on weekends and at times convenient for the family.
- An agency handbook, which includes a grievance and appeals procedure, is written in clear and understandable language.
- Personnel ensure that families get copies of the agency handbook and understand who to call for help with questions.
- Consumer satisfaction protocols include items specific for families of children and adolescents.
- Families of children and/or adolescents are involved on the agency/management board or a family/community advisory committee to the agency.
- The agency handbook indicates that child and adolescent specialists can be requested by the family to provide treatment services for their child.
- The agency handbook contains information for families regarding the availability of training and education to assist them in supporting their child through the treatment process.
Narrative summarizing how the “family-focused” principle will be strengthened in plan year 2001-2002:
III. Community-based

The Principle: Whenever possible, services are delivered in the child’s home community, drawing on formal and informal resources to promote the child’s successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

The Indicators for County Mental Health Programs:

YES    NO

[ ]   [ ]  County office maintains a list of resources within the zip code or within 10 miles.

[ ]   [ ]  Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in the office.

[ ]   [ ]  Natural and community resources are used in the CASSP service plan, such as family, neighbors, school, work, leisure and church activities.

[ ]   [ ]  Orientation to and support for public transportation are available to families.

[ ]   [ ]  The data system tracks the use of local/community resources.

[ ]   [ ]  The county funds outreach programs.

[ ]   [ ]  The staff training schedule includes topics on community resources and understanding the community in which the staff works.

[ ]   [ ]  The county has identified gaps in the service system and has developed a plan to address them.

[ ]   [ ]  The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

All    Most    Some    Few

[ ]       [ ]       [ ]       [ ]  county funded agencies demonstrate

All    Most    Some    Few

[ ]       [ ]       [ ]       [ ]  of the following:

The Indicators for Agencies:

- Resources within the zip code or within 10 miles are used.
- Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in service management offices.
- Natural resources are used in each treatment plan, such as family, neighbors, school, work, leisure and church activities.
- Orientation to and support for public transportation are available to families.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to families and their children when needed.
The staff training schedule includes topics on community resources and understanding the community in which the staff works.

If community-based resources are not available for a family, there is an administrative/financial plan to address the service gap.

Records of community involvement and participation are maintained.

Narrative summarizing how the “community-based” principle will be implemented in plan year 2001-2002:
IV. Multi-system

The Principle: Services are planned in collaboration with all the child-serving systems involved in the child’s life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

The Indicators for County Mental Health Programs:

YES    NO

[ ] [ ] A CASSP Advisory/Management Committee meets at least quarterly and includes representatives of each of the child-serving systems.

[ ] [ ] Directors of MH/MR, Drug & Alcohol, Children and Youth, Special Education, Juvenile Probation, meet at least quarterly to discuss children’s issues.

[ ] [ ] The CASSP Coordinator is responsible for assuring coordination among MH providers and child-serving systems in the county.

[ ] [ ] Intersystem children’s needs assessment occurs on an annual basis with input from all CASSP participants.

[ ] [ ] Intersystem professionals have input into county plans.

[ ] [ ] CASSP projects provide input for annual plans which address local children’s service gaps and priorities for agencies including Children and Youth, Education/Special Education, Drug & Alcohol, Juvenile Probation, Mental Health, and Mental Retardation.

[ ] [ ] Cross-system training occurs routinely, and/or agencies routinely invite other system staff to scheduled training.

[ ] [ ] An intersystem conflict resolution process is established and reviewed/revised as needed.

[ ] [ ] An intersystem release of information procedure is established and integrated into staff orientations.

[ ] [ ] An intersystem forum to develop/review treatment/service plans for children needing multi system support meets regularly with all major child-serving systems participating.

[ ] [ ] Child-serving system directors have formal or informal input into the CASSP Coordinator’s performance evaluation.

[ ] [ ] Fiscal procedures to implement shared funding of children’s services are developed.

[ ] [ ] The local ideal system of care for children has been described.

[ ] [ ] Proposals for new children’s services to state offices routinely include support letters from each of the child-serving systems.
Procedures to coordinate discharge planning for children and adolescents returning from community inpatient units, residential treatment centers, mental retardation centers, youth development centers and forestry camps and/or other out-of-county group care settings are established with mechanisms to ensure continuity for the child, aftercare, and establishment of “lead” or joint case management.

A local Student Assistance Program coordinating mechanism is in place.

Each of the major child-serving systems agrees that the local CASSP project has addressed intersystem issues which affect their own target populations.

Shared funding of children’s services based on an individualized service plan occurs routinely for children/adolescents requiring multi-system support.

Early Intervention issues and coordination have been addressed by the system directors.

**Other county level indicators:**

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County funded agencies demonstrate the following:

**The Indicators for Agencies:**

- Families and, if they choose, an advocate/support person participate in the interagency meeting as members of the team.
- Interagency team meetings are held in a convenient and comfortable room with access to blackboard/newsprint, etc.
- At a minimum, mental health and education personnel are involved in interagency team meetings for children and adolescents who are of school age.
- Child-serving systems and other persons/informal support systems involved with the child are included in the treatment process as documented in telephone calls, conferences and interagency meetings.
- Letters of agreement with each child-serving system are current (for each fiscal year) and include a conflict resolution protocol.
- Procedures are written for convening the interagency team, including when meetings are called, who calls them and who leads them.
- Each child’s service plan reflects the contribution of each involved service system.
- The data system reports cross-system outcome measures.
- Individual practitioners/agency/MCO staff are knowledgeable and participate in the county child-serving system’s collaborative structure.
- Progress notes reflect a summary of interagency team meetings and attendees, and are distributed to the team.
Narrative summarizing how the “multi-system” principle will be strengthened in plan year 2001-2002:
V. Culturally competent

The Principle: Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, custom, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania’s cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] A CASSP Advisory/Management Committee meets at least quarterly and includes persons representing the cultural diversity of the county.

[ ] [ ] The county office has resources and materials that reflect the cultural diversity of the county.

[ ] [ ] Persons of various cultural backgrounds representative of the county have input into county plans.

[ ] [ ] Cross-system training includes a component on cultural competence for administrators, supervisors, and direct service staff.

[ ] [ ] Orientation procedures to county staff include cultural competence values and issues.

[ ] [ ] Persons of color, ethnic and religious groups are provided the opportunity to comment on the cultural appropriateness of the service they or their child received.

[ ] [ ] Assessment of the cultural diversity and competencies of local staff and clients has promoted the development of strategies to move toward a culturally competent system of care.

[ ] [ ] Local CASSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/service African, Latino, Asian, or Native American cultures.

[ ] [ ] County administrative and direct care staff represent the cultural diversity of the county.

[ ] [ ] Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

[ ] [ ] County staff are trained in Deaf Culture and other cultures, communication skills and the distinction related to language, syntax, and expression of feelings in the culture.

[ ] [ ] County staff are trained in the protocol and use of interpreters.
county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the cultural diversity of the people served by the agency.
- Waiting rooms and offices have literature reflecting the ethnic groups in the community.
- The schedule of regular staff training includes cultural competence development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural competence including specifics on local cultural diversity
    - the principles of cultural competency development
    - conducting psychiatric and psychological assessments applicable to the individual’s cultural context
    - treatment planning appropriate to the individual, family, and cultural context
    - integrating community supports and resources
    - considering and using non-traditional methods and services
    - direct service provision and effectively engaging minorities in treatment
    - more advanced trainings involve issues and related topics
- Service delivery reflects:
  - psychiatric assessments which incorporate an appreciation of the child’s or adolescent’s culture and level of acculturation
  - treatment plans/consultations which involve or reflect the family’s cultural perspective
  - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
  - recognition of the importance of religion, religious expression and religious institutions
  - services available from clinical staff who speak the language understood by children and families or who use interpreters
  - interagency meetings which welcome extended family members
  - recognition of culturally relevant holidays and traditions
  - tracking of completion rates for appointments by ethnicity, age, and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.
Narrative summarizing how the “culturally competent” principle will be strengthened in plan year 2002-2002:
VI. Least restrictive/least intrusive

The Principle: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] Review of service data over the past several years shows a decrease in out-of-state and out-of-county placements; a decrease in inpatient days; a decrease in residential treatment days; an increase in community-based utilization, especially use of natural supports.

[ ] [ ] The county maintains a list of available local resources.

[ ] [ ] County staff communicate with children and their families to ensure there is comfort with the intensity and frequency of services, especially those services that are provided in the home, the school, or other natural locations.

[ ] [ ] Family-friendly consolidation by county staff in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.

[ ] [ ] In-home, in-school and in-community resources are considered by the county before out-of-home placement, or as part of a discharge plan when returning from placement.

[ ] [ ] Justification for each service or placement considered for children and adolescents is documented by the county.

[ ] [ ] The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Other county level indicators:

All Most Some Few

[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Family-friendly consolidation in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
- The community integration questionnaire is used to ensure the use of least restrictive services.
- In-home, in-school and in-community resources are safely used first before out-of-home placement is considered or as part of a discharge plan when returning from placement.
• Justification for each service or placement considered is documented.
• The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Narrative summarizing how the “least restrictive/least intrusive” principle will be strengthened in plan year 2001-2002:
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CSP Principles
For County Mental Health Programs

Instructions: The Local CSP Advisory Committee should receive a copy of the Indicators of the Application of the CSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CSP Advisory Committee shall then forward the completed document to the MH/MR Administrator’s Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a “yes” or “no” response.

2. The second set is applicable to individual agencies. Please indicate the responses “All”, “Most”, and “Some”, or “Few”, that best describe the presence of the agency indicators in the county program.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for “no” responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened.

I. Consumer-center/Consumer-empowered

The Principle:
Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.
The Indicators for County Mental Health Programs:

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<td>County office staff are courteous, respectful, and willing to assist consumers and family members either in person or on the telephone.</td>
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<td>There is a county staff person designated as the CSP Liaison.</td>
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<td>County staff overseeing adult mental health services reflect appropriate qualifications, including orientation to and training in CSP principles.</td>
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<td>The county has integrated orientation to CSP values for all has become an integrated new county administrative, supervisory, and direct service staff.</td>
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<td>County staff, including case managers, consider consumer choice and preference in the selection of services and treatment.</td>
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<td>Consumers are included in CSP meetings.</td>
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<td>Data elements collected by the county during program evaluations include factors identified in the state Performance Outcome Management System (POMS) and reflects outcomes important to consumers (e.g., employment, housing, transportation, and social supports).</td>
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<td>The CSP Liaison is provided opportunity for training in adult mental health issues.</td>
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<td>County staff encourage family members to participate in service and treatment decisions.</td>
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<td>Consumers are integrally involved in planning, developing, and implementing new services and in the evaluation of services.</td>
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<td>Consumers and families are involved in the county plan development.</td>
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<td>Consumer and families participate in the budget meetings with county and state mental health staff.</td>
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<td>The county program promotes and funds consumer self-help and consumer-run alternatives.</td>
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<td>County personnel policies and practice encourage the hiring of consumers as staff, consultants, and trainers.</td>
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<td>The county program uses people first language in all written materials (e.g.,</td>
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people with schizophrenia, not schizophrenics).

[ ] [ ] The county program makes information available to consumers on the self-help philosophy and statewide and local consumer organizations.

[ ] [ ] Notice of public/special hearings is widespread throughout the mental health community as well as in newspapers at least two weeks prior to the event.

[ ] [ ] Public/special hearings are held in locations accessible to public transportation, or transportation is arranged where no public transportation exists.

[ ] [ ] County staff are trained on consumer self-help approaches and the concept of recovery from mental illness.

[ ] [ ] Consumers are involved in all service and treatment decisions affecting their lives and given choice and preference in accessing/utilizing services.

Other county level indicators:

[ ] [ ] Consumers with special needs, including but not limited to persons who are deaf, hard of hearing, deafblind, elderly, etc and their families, are involved in county plan development, program assessment of need, implementation and evaluation of services, and participate in budget meetings with county and state mental health staff.

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, braille, readers, etc. in assisting consumers with special needs from initial intake, through assessment, planning, intervention and after care services, and that the communication tool of the consumer's choice is utilized.

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County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Consumers are integrally involved in designing and evaluating services.
- Consumer preferences are honored whenever possible (e.g., therapist/case manager, decor, living arrangements, programming, food selection, etc.).
- Consumer self-help and consumer-run alternatives are promoted and funded.
- Individual strengths, interests and resources are identified in assessments, treatment plans...
and progress notes.

- Treatment/service plans reflect consumer involvement in goal setting and decisions regarding services. Consumers' signatures appear on all treatment/service plans, or an explanation of why the consumer has not signed is noted.
- Personnel policies encourage the hiring of consumers as staff, consultants, trainers.
- Consumer confidentiality is honored.
- People First language is used in all written materials (e.g., people with schizophrenia not schizophrenics).

Information is available to consumers on self-help philosophy and statewide and local consumer organizations.

YES NO

- Data collection reflects outcomes important to consumers (e.g., employment, housing, social supports).
- Provider staff are trained on the concept of recovery from mental illness and promote recovery concepts to consumers

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

II. Culturally Competent

The Principle:

_Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are designed and delivered to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices of an individual or a particular group of people._

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] A County CSP Committee meets regularly and includes persons reflective of the county cultural/ethnic groups.

[ ] [ ] The county office has resources and materials that reflect the cultural diversity of the county.
Persons from minority cultures have input into county plans.

Training includes a component on cultural competence for administrators, supervisors, and direct service staff.

Training teams represent the ethnic groupings of the county.

Orientation procedures to county staff include cultural competence values and issues along with other CSP values.

Consumer satisfaction surveys include a request for persons of cultural minorities to comment on the cultural appropriateness of the service they received.

Assessment of the cultural diversity and competencies of local staff and clients are used in the development of strategies to move toward a culturally competent system of care.

Local CSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/serve African, Latino, Asian, Native American, or other local cultural groups.

Administrative staff represent the cultural diversity of the county.

Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

County staff are trained in Deaf Culture and other cultures, communication skills and the nuances related to language, syntax, and expression of feelings in the culture.

County staff are trained in the protocol and use of interpreters.

All Most Some Few
county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:
The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the diversity of the population the agency serves.
- Waiting room and offices have literature reflecting the ethnic groups in the community.

- The schedule of regular staff training includes cultural competency development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural diversity
  - the principles of cultural competency development
  - conducting psychiatric and psychological assessments applicable to the individual's cultural context
  - treatment planning appropriate to the individual, family, and cultural context
  - integrating community supports and resources
  - considering and using non-traditional methods and services
  - direct service provision and effectively engaging minorities in treatment

- Service delivery reflects:
  - psychiatric assessments which incorporate an appreciation of the consumer's culture and level of acculturation
  - treatment plans/consultations which involve or reflect the family's cultural perspective
  - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
  - recognition of the importance of religion, religious expression and religious institutions
  - services available from clinical staff who speak the language understood by the consumer or who use interpreters
  - interagency meetings which welcome extended family members
  - recognition of culturally relevant holidays
  - tracking of completion rate for appointments by ethnicity, age and gender

- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened:

III. Flexible
**The Principle:** The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times, and delivered in a wide range of environments.

**The Indicators for County Mental Health Programs:**

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**Other county level indicators:**

| []  | [] | The county has an outreach team to identify elderly people and other people with special needs who are in need of mental health services. |

**All**  **Most**  **Some**  **Few**  **All**  **Most**  **Some**  **Few**

| []  | []  | []  | [] | county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following: |

**The Indicators for Agencies:**

- A full array of treatment, rehabilitation and support services are available in accessible locations.
- Day, evening and weekend hours are available.
- Services are delivered at a variety of locations, including the consumer's home or community as appropriate.
- Type and duration of service is based on consumer need.
• Staff credentialing standards recognize expertise in rehabilitative, self-help and alternative treatment approaches.

Narrative summarizing how the "flexible" principle will be strengthened:

IV. Meet Special Needs

The Principle:

*Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, mental retardation, homelessness, HIV/AIDS, and involvement in the criminal justice system.*

The Indicators for County Mental Health Programs:

YES  NO

[ ] [ ] The county program actively collaborates with other human service agencies to meet the needs of consumers with special needs.

[ ] [ ] The county program supports creative inter-agency agreements, collaborative funding, and cross-system training of staff.

[ ] [ ] The county program tracks and/or coordinates outreach to special needs populations.

[ ] [ ] The county solicits input from other service agencies when planning, developing, or expanding services.

[ ] [ ] County staff training includes modules on special populations.

[ ] [ ] The county program has designated staff specialists for special populations.

Other county level indicators:

[ ] [ ] The county program actively seeks and utilizes input from persons with special needs, their family members and advocates, in the development of county plans.

[ ] [ ] The county program provides the necessary communication tools/qualified interpreters/large print materials/assistive hearing devices, etc. to enable persons with special needs to participate in the county plan development.
The county program ensures that a discharge plan for those being discharged from the criminal justice system involves networking with the criminal justice system and all systems which will enable a successful transition.

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county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Representatives from other service systems are involved in developing/implementing the treatment/service plan of persons with special needs.
- Staff specialists are available/trained to meet the diverse needs of consumers, as outlined above.
- Timely mobile outreach is provided to specialty populations including persons who are elderly, homeless and involved in the criminal justice system.
- Data systems track service utilization and outcomes specific to special populations.
- TDD telephone access, sign language interpreters, Braille materials and other assistive devices are available, as needed.
- Creative interagency agreements and funding focus on the total needs of the individual (cross-training of staff, co-location of staff, etc.).

Narrative summarizing how the "meet special needs" principle will be strengthened:

V. Accountable

The Principle:
Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring and evaluating services.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] The county program supports CSP activities at local, regional, and state levels.

[ ] [ ] The county ensures consumers understand service options and how to access services.

[ ] [ ] County documents including county annual plans, reports, and newsletters are written in language that is understandable to consumers.
[ ] [ ] The county program provides a consumer-friendly complaint, grievance, and appeal system.

[ ] [ ] The county program collects consumer satisfaction data, and prepares and distributes reports to consumers, advocates, and providers.

[ ] [ ] The county maintains a continuous quality improvement plan for services, outcomes, and access.

[ ] [ ] The county has a consumer satisfaction team (which is independent of county providers, staffed by consumers/family members, and where members earn competitive wages.)

[ ] [ ] Consumer satisfaction data indicates that consumers and families are treated with respect and dignity.

Other county level indicators:

[ ] [ ] Consumer satisfaction data indicates that input has been sought from consumers with special needs, such as persons who are deaf, hard of hearing, deafblind, elderly, having HIV/AIDS, etc. and that the data indicates that consumers with special needs are treated with respect, dignity, and that they understand service options, and how to access services.

[ ] [ ] The county has open/closed captioned videos, large print materials, assistive hearing devices and other communication tools available to help consumers with special needs understand their rights, service options and how to access services.

All  Most  Some  Few             All  Most  Some Few
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Consumers and families are integrally involved in the design, development and evaluation of services. This includes:
  - Consumer satisfaction teams.
  - Consumer/family membership on governing/advisory boards.
• Information on services, diagnoses, medications, etc. is available and written in consumer friendly language.
• The member handbook/policies and procedures, which includes grievance and appeal procedures, is written in clear and understandable language.
• Personnel ensure that consumers receive copies of the member handbook/policies and procedures and understand who to call for help with questions.

• The agency has positive outcome measures aimed towards stabilization/growth in functioning, increased consumer satisfaction, etc.
• The agency has a balanced focus on cost, quality, outcome and access, when evaluating program success.
• Data and standards related to demographics, budgets/expenditures, criteria for service authorizations, complaints/appeals, outcomes, etc. are provided to consumers/families and advocates for review.

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

VI. Strengths-Based

The Principle:
*Services build upon the assets and strengths of consumers to promote growth and movement toward independence.*

The Indicators for County Mental Health Programs:

YES  NO

[ ] [ ] The county program promotes recovery from mental illness.

[ ] [ ] The county program facilitates opportunities for consumer growth and independence.

[ ] [ ] The county program assures that assessments, treatment/service plans, and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.

[ ] [ ] The county program assures that written materials support People First language and the role of the consumer as a key partner in the recovery process.
The county maintains a continuum of services allowing individuals to maintain the highest level of independence possible.

Self-help and consumer run services are funded and available.

**Other county level indicators:**

The county continuum of services allows individuals who have special needs to maintain the highest level of independence possible and the county networks with advocacy groups for persons with special needs to identify all resources available for the consumer to maintain the highest level of independence possible.

**The Indicators for Agencies:**

- Service interventions promote a wellness, not illness, focus.
- Assessments, treatment/service plans and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
- Written materials support People First language and the role of consumer as a key partner in the recovery process.
- Staff are trained in the concept of recovery from mental illness.
- The concept of recovery is promoted by providers.

**Narrative summarizing how the "strengths-based" principle will be strengthened:**

**VII. Community-Based/Natural Supports**

**The Principle:**

*Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.*
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**Other county level indicators:**

| [ ] | [ ] | The county office insures that its staff and the contract provider staff are knowledgeable of and utilize natural and community supports which benefit consumers with special needs. Staff training includes presentations from consumers with special needs, as well as their family members and advocates. |

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**The Indicators for Agencies:**

- Community based resources/services within the zip code or within 10 miles are used.
- Pamphlets/information on local resources and services are made available through administrative entities and provider agencies.
• Training and support in finding and using transportation is available to consumers.
• Natural resources are used in each treatment plan, such as housing, work, leisure and church activities.
• Consumers are encouraged to develop advance directives in preparation for crises for staff/family to follow.
• Individuals identified by the consumer as supports should be incorporated into the treatment/service plan.
• The data system tracks the use of local/community resources.
• There is a policy/procedure to reach out to consumers and their families when needed.
• The staff training schedule includes topics on community resources and understanding the community in which the staff works.

Narrative summarizing how the "community-based/natural supports" principle will be strengthened:

VIII. Coordinated

The Principle:

Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.

The Indicators for County Mental Health Programs:

County staff orientation and training includes an overview of various human services agencies.

YES   NO

[ ] [ ] County program staff are designated as liaisons with other human service systems.

[ ] [ ] County staff are available to provide orientation to other agencies regarding mental health services.

[ ] [ ] The county program ensures that written agreements/plans for coordination are in place with providers and agencies including: state-hospitals, medical services providers, social services agencies, and police and corrections offices.

Other county level indicators:

[ ] [ ] The county staff and contracted provider staff receive and provide

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements - Primary Contractor
orientation to agencies serving persons who have special needs. These agencies include but are not limited to the Office for the Deaf and Hard of Hearing, The Department of Aging and the Area Agencies on Aging, the Coalition for the Homeless, etc.

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| county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Written agreements/plans for coordination are in place with the following:
  - State hospitals.
  - Medical services providers/insurers. (This should include a good baseline medical work-up, coordination in monitoring physical and neurobiological services, etc.)
  - Social service agencies (Offices of aging, vocational rehabilitation, housing authorities, drug and alcohol programs, homeless shelters, legal services, etc.)
  - Police departments, district justices, jails and prisons, etc.
- Staff are designated as liaisons to other service agencies in order to plan and facilitate services.
- Staff development/training involves overview of service agencies in area (e.g., policies, procedures, mission statement, regulations, etc.).

Narrative summarizing how the "coordinated" principle will be strengthened:
Background
Alcohol and other drug abuse and dependency treatment services must be provided by facilities licensed by the Department of Health's Division of Drug and Alcohol Program Licensure, to ensure that minimum standards are being maintained to protect the health, safety and welfare of the client.

Philosophy
Substance abuse and dependence are primary diseases, not symptoms of other underlying conditions. Substance use disorders can be diagnosed, are responsive to treatment and are complex behavioral disabilities usually having chronic medical, social and psychological components, which result in multiple negative consequences. Substance abuse and dependence related problems affect not only the dependent individual, but other family members, particularly children. Denial is a central characteristic or symptom of substance abuse and dependence that complicates an individuals ability to acknowledge a problem.

Principles
□ Treatment needs to be readily available. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

□ No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

□ Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must not only address the individual's drug use but any associated medical, psychological, social, vocational, and legal problems.

□ Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because addictive disorders and mental disorders often occur in the same individual, persons presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder. Both disorders are considered primary.
Treatment should be client specific and guided by an individualized treatment plan based upon a face to face comprehensive biopsychosocial evaluation of the patient and when possible, a comprehensive evaluation of the family as well.

Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and Double Trouble are essential adjuncts to the treatment process. Attendance should be encouraged when appropriate.

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Methadone and buprenorphine very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. Treatment may include Residential care followed by Intensive Outpatient care or Partial treatment followed by Outpatient care, or any movement through the level of care continuum. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely,
programs should include strategies to engage and keep patients in treatment.

- **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining long-term abstinence.

- **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

- **Persons recovering from alcoholism or other drug dependencies are viewed as important resources in the statewide service system.** As representatives of the recovering community, persons in recovery serve as an inspiration to the addicted client. As a practicing professional they provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for patient advocacy.
BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS (BH-MCOs)
PERFORMANCE/OUTCOME MANAGEMENT SYSTEM (POMS)

A. **OVERVIEW**

The POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources (see attached table of outcome measures and data sources). The database, which is maintained and managed by the Department of Public Welfare, contains an extensive array of raw data concerning enrollees in the BH-MCOs. The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. The Department will utilize the performance measures/indicators as its primary tool for continuously evaluating the effectiveness of the BH-MCO contractors in achieving a variety of systems level outcomes.

The POMS serves the following primary functions:

1. Provides accountability for public funds expended through the Department’s capitation payments to the BH-MCO contractors.
2. Provides a fair and objective evaluation of the BH-MCOs that the Department can use for implementing outcome oriented incentives and sanctions.
3. Supports the Department and the BH-MCO contractors to implement a collaborative continuous Quality Improvement process.

B. **DATA COLLECTION PROCESSES**

Raw data concerning BH-MCO enrollees, obtained from a variety of sources, will be transmitted via batch file extracts to the POMS central database (see attached flow chart). The data will be linked and integrated for each BH-MCO enrollee based on unique identifiers. The integrated database will provide the basis for DPW to derive quantitative performance indicators/measures that reflect systems level outcomes achieved by each BH-MCO primary contractor. The primary data sources and data collection processes are as follows:

1. **BH-MCO Encounter Data** - BH-MCOs, through a process similar to what DPW required for the HealthChoices PH-MCOs, will submit data files on a regular schedule to DPW. The data will be edited and then loaded into DPW’s Enterprise Data Warehouse. The Office of Mental Health and Substance Abuse Services (OMHSAS) will, on a regular schedule, receive a file of all DPW accepted encounter records and will perform additional edits before loading to the POMS central database.

2. **Enrollee Eligibility and Demographic Data** - DPW will on a regular schedule move enrollee eligibility and demographic data from its Client Information System (CIS) into the Enterprise
Data Warehouse. OMHSAS will subsequently pull a subset of eligibility and demographic data elements via data file extracts into the POMS central database.

3. **Secondary Data** - OMHSAS will develop data exchange agreements with other state agencies, as feasible, to obtain regularly scheduled data file extracts that will be loaded into the POMS central database. Data exchanges with state agencies such as the Department of Corrections, State Police and the Department of Education are under development.

4. **Consumer/Family Satisfaction Reports** - There will be standardized measures administered by the BH-MCO. A Co-occurring Disorder (COD) question must be included on the survey and a sampling of COD consumers must be surveyed. The BH-MCO will submit reports of findings to the DPW. A survey will be conducted annually.

5. **BH-MCO Consumer Registry File** - BH-MCOs will maintain a computerized registry of their enrollees who have accessed behavioral health services. The registry is comprised of a minimum data set including clinical descriptions such as priority population and critical dates during the episode of care such as date of first service request, registration date and termination date. These data will be submitted by the BH-MCOs to the POMS central database.

6. **BH-MCO Quarterly Status File** - BH-MCOs will maintain a computerized file concerning the status of priority populations. The file will be updated on a calendar quarter basis for each enrollee in the priority population. The quarterly status file is comprised of a minimum data set including outcome measures such as vocational/educational status and independence of living arrangement. These data will be submitted by the BH-MCOs to the POMS central database on a regular schedule.

7. **Performance Indicator Reports** - On a regular schedule, DPW will produce from the POMS central database a set of performance indicators that measure the performance of each BH-MCO consistent with the outcome dimensions outlined in the attached table of outcome measures. The performance indicator reports will be issued by DPW on a regular schedule to all relevant DPW monitoring staff, the BH-MCOs and other stakeholder groups.

C. **CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS**

The Department encourages the BH-MCOs to implement a Continuous Quality Improvement (CQI) process based upon Deming's 14-point program for managed adapted to the health care industry, and Joint Commission on Accreditation of Health Care Organization (JCAHO) guidelines. The overall process should include:

- Delineating the scope of the services to be monitored and improved.
- Identifying the important aspects of the services whose quality should be examined and improved.
- Identifying indicators (including but not limited to the performance indicators established by DPW) that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.
- Establishing thresholds (including but not limited to the thresholds established by DPW) for the review of indicators that become “flags” signaling the need for further analysis of the causes for the data reported to DPW.

Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.

- Initiating analyses of other important aspects of services when thresholds have been reached.

- Taking actions to improve the aspects of services.

- Reporting the findings to the organizations involved, including a report of findings to DPW on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

DPW monitoring staff will review the CQI reports of findings submitted by the BH-MCOs. DPW monitoring staff will provide feedback to BH-MCOs indicating:

1. Concurrence with the BH-MCOs explanation/cause of the performance indicator findings and actions proposed by the BH-MCOs to improve performance (and/or correct deficiencies); or

2. Offer alternative explanations/causes for the performance indicator findings and/or recommended alternative actions to improve performance (and/or correct deficiencies).
### BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS
#### PERFORMANCE/OUTCOME MANAGEMENT SYSTEM

<table>
<thead>
<tr>
<th>OUTCOME DIMENSIONS</th>
<th>DATA SOURCE(S)</th>
</tr>
</thead>
</table>
| **1. Increase Community Tenure and Less Restrictive Services**<sup>*</sup>  
  ▪ Increase the appropriate use of behavioral health inpatient days.  
  ▪ Decrease criminal incarcerations.  
  ▪ Increase the appropriate use of MH residential care.  
  ▪ Decrease out-of-home placements.  
  ▪ Decrease homelessness.  
  ▪ Increase residential stability.  
  ▪ Decrease patient days in state mental hospitals.  
  *To be reported/compiled only for priority group consumers by age group (under age 21, 21-64 and age 65+). | 1. Quarterly Status File (QSF)<sup>†</sup>  
  2. Criminal incarceration data sets from state correctional institutions, county jails and juvenile court records.  
  3. BH encounter data and SMH data set (PCIS). |
| **2. Increase Vocational and Educational Status**<sup>*</sup>  
  ▪ Increase school attendance (full time regular classroom)  
  ▪ Increase school retention.  
  ▪ Increase school performance.  
  ▪ Improve school behavior.  
  ▪ Increase vocational status for adults.  
  *To be reported/compiled only for priority group consumers by age group. | 1. Quarterly Status File (QSF)<sup>†</sup>  
  2. Employment tax records. |
<table>
<thead>
<tr>
<th>OUTCOME DIMENSIONS</th>
<th>DATA SOURCE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Reduce Criminal/Delinquent Activity*</td>
<td>1. Quarterly Status File (QSF)¹</td>
</tr>
<tr>
<td>▪ Reduce number of arrests.</td>
<td>2. Arrest records (state police)</td>
</tr>
<tr>
<td>▪ Reduce positive drug screens.</td>
<td>3. Probation and Parole records</td>
</tr>
<tr>
<td>▪ Improve probation/parole status.</td>
<td>4. Automated Health Systems</td>
</tr>
<tr>
<td>▪ Reduce status offenses. (focus on truancy)</td>
<td>5. AOPC records</td>
</tr>
<tr>
<td>*To be reported/compiled only for priority group consumers by age group.</td>
<td></td>
</tr>
<tr>
<td>4. Improve Health Care*</td>
<td>1. Encounter data from physical health HMOs.</td>
</tr>
<tr>
<td>▪ Meet or exceed DPW's EPSDT screening targets.</td>
<td>2. 837I HIPAA Compliant Transaction Institutional.</td>
</tr>
<tr>
<td>▪ Increase % of consumers with annual physical exams.</td>
<td>3. 837P HIPAA Compliant Transaction Professional.</td>
</tr>
<tr>
<td>▪ Reduce hospital medical ER use.</td>
<td></td>
</tr>
<tr>
<td>*To be compiled only for priority group consumers by age group.</td>
<td></td>
</tr>
<tr>
<td>5. Increase “Penetration Rates” (i.e., percent of enrollees who received behavioral health treatment through the behavioral health contractor)</td>
<td>1. Consumer Registry File (CRF)²</td>
</tr>
<tr>
<td>▪ Increase appropriate utilization by priority group and type of service.</td>
<td>2. 837I HIPAA Compliant Transaction Institutional.</td>
</tr>
<tr>
<td>▪ Increase appropriate utilization by age and type of service.</td>
<td>3. 837P HIPAA Compliant Transaction Professional.</td>
</tr>
<tr>
<td></td>
<td>4. Automated Health Systems</td>
</tr>
<tr>
<td>6. Increase Consumer/Family Satisfaction*</td>
<td>1. Consumer Registry File (CRF)¹</td>
</tr>
<tr>
<td>*To be reported/compiled only for priority group consumers.</td>
<td>2. Consumer/Family Satisfaction Measurement Instruments</td>
</tr>
</tbody>
</table>

Appendix K
1/1/08
### OUTCOME DIMENSIONS | DATA SOURCE(S)
--- | ---
7. *Implement Continuous Quality Improvement (CQI) Actions* | 1. CQI Periodic Reports – Behavioral health contractor must submit to DPW periodic narrative reports detailing its CQI activities, delineating deficiencies and areas for improvement, actions taken to improve performance (or remedy deficiencies) and the effectiveness/outcome of actions taken. CQI reports must address performance indicator reports issued by OMH.

8. *Increase Range of Services and Improve Utilization Patterns* | 1. 837I HIPAA Compliant Transaction Institutional.  
   2. 837P HIPAA Compliant Transaction Professional.  
   3. Encounter data from physical MCOs.
   - Improve/increase the array of treatment, support and rehabilitative service options.  
   - Decrease % of priority group consumers using only inpatient and/or ER services.  
   - Reduce inpatient re-hospitalization rate.  
   - Reduce rate of perinatal addictive disorders.  
   - Reduce “drop-out” rate.

9. *Implement co-occurring disorder (COD) Performance Indicator or QA measure* | 1. BH-MCO self reporting  
   - Improve/increase identification of co-occurring recipients  
   - *Increase the percentage of network providers that routinely screen and assess for co-occurring psychiatric and substance use disorders.*

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¹Reporting requirements and Data elements for QSF are in the Proposers’ Library.  
²Reporting Requirements and Data elements for CRF are in the Proposers’ Library.

** HIPAA Implementation Guides and Addenda** for the various types of transactions are available, free of charge, from the Washing Publishing Company at [www.wpc-edi.com/hipaa/](http://www.wpc-edi.com/hipaa/). These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** Pennsylvania PROMISe Companion Guides*** for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed...
information specific to the submittal of claims and encounter transactions to Pennsylvania’s PROMIS\text{e} system.
HealthChoices COD Performance Indicators/QA Measures

Please use the following operational definitions and reporting specifications for required DPW COD performance indicators/QA measures referenced in Appendix K.2

Operational definitions:

Co-occurring disorder: Individuals with a co-occurring disorder have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Screening: A formal process that is typically brief and occurs soon after the individual presents for services. The purpose of the screening process is to determine the likelihood that a person has a co-occurring disorder, not to establish the presence or specific type of disorder, but to determine the need for an assessment. (No mandated instrument)

Assessment: A formal process of gathering information and engaging with the individual that enables the provider to establish the presence or absence of a co-occurring disorder that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. The purpose of the assessment is to establish the existence of a clinical disorder or service need and to work with the individual to develop a treatment plan. (No mandated instrument)

Specific reporting criteria:
(unduplicated count, quarterly review and annual report)

1. Increase the percentage of network providers that routinely screen and assess for co-occurring mental health and substance use disorders:

   Total number of network providers: ______
   Number of network providers that have a written policy/procedure requiring individuals to be screened and assessed for co-occurring disorders: ______
   Total number of individuals screened and/or assessed for a co-occurring disorder: ______

2. Increase identification of co-occurring recipients (prevalence):
   Per Network provider:

   Total number of individuals admitted to the program: ______
   Total number of individuals determined to have a co-occurring disorder that have been admitted to the program: ______
   Total number of individuals determined to have a co-occurring disorder referred to another treatment provider: ______
GUIDELINES FOR CONSUMER/FAMILY SATISFACTION TEAMS
AND MEMBER SATISFACTION SURVEYS

The Department of Public Welfare (DPW) values and encourages the input of consumers and families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS) encourages input from consumers, persons in recovery, and families regarding the services and supports received in the mental health and drug and alcohol service system. Consumer and family feedback helps inform Providers, counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support recovery for adults, resilience in children and adolescents and be more effective. Consumers and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is not their service Provider. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements DPW therefore requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- A Consumer/Family Satisfaction Team (C/FST) Program
- An Annual Mailed/Telephonic Survey of Member Satisfaction

A. CONSUMER and FAMILY SATISFACTION TEAM PROGRAM

1. Purpose
The purpose of the C/FST Program is to determine whether adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. Surveys should identify consumer and family member satisfaction with the services of a specific Provider as well as the level of satisfaction with the behavioral health system and all of the treatment, services and supports each consumer is receiving. This is primarily accomplished by gathering information through face-to-face discussions with Recipients of behavioral health services and the families of child and adolescent service Recipients, with follow-up reports, dialogue, and problem resolution feedback with the Primary Contractor.

It is the responsibility of the Primary Contractor (the Primary Contractor refers to the responsible party that holds the HealthChoices contract or agreement with DPW) to provide the support, encouragement, and resources necessary to build a strong, independent, conflict free C/FST Program. In a recovery oriented service system support and encouragement would be evidenced by a Primary Contractor that:
• Communicates the importance of listening to and acting upon the results of satisfaction feedback from C/FSTs;
• Supports and encourages C/FSTs so that they are considered a respected and valuable service;
• Requires timely Provider action in response to survey results;
• Has a Provider network that works in partnership with C/FSTs to continuously improve service responsiveness using survey results in their internal quality management program;
• Identifies system improvement needed based on survey results;
• Actively provides direction and feedback to C/FSTs about how to improve their program and acquire the skills needed to move toward the independent operation of a satisfaction survey program; and
• Provides the resources necessary to accomplish the requirements outlined in this document.

2. Organizational Requirements of Consumer/Family Satisfaction Team Programs

In order to determine whether or not behavioral health services are meeting the needs and expectations of adults, young adults, children and adolescents and their family members, the Primary Contractor shall ensure that the C/FST Program is organized and operates in compliance with the following:

The Primary Contractor either directly, or via a BH-MCO or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The C/FST Program may be either a single or a multi-county program based upon the nature of the contract between DPW and the Primary Contractors. The family satisfaction component may be accomplished either as a separate administrative entity or as a component of the C/FST Program that is specifically responsible for family satisfaction activities.

(a) The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a written and signed agreement with each C/FST Program and fiduciary, if applicable, that delineates roles and responsibilities of all parties. Designation of who holds the responsibility for advocacy and follow-up on behalf of Members should also be included.

(b) Under the contract or written agreement, and consistent with the requirements of the Mental Health Procedures Act (Chapter 5100), the C/FST members will act as agents of the Primary Contractor, and are, therefore, to have the same access to consumers and family members as the Primary Contractor and service Providers, insofar as it is necessary to perform their responsibilities.
(c) Each C/FST Program must have a Director who may be full or part time depending upon the size of the program. The Director must be a person who self-identifies as a consumer, person in recovery, or family member as stated in 3(a) and (b) as of January 1, 2005. If the current Director hired prior to January 1, 2005 does not meet this requirement, he or she may continue to serve until such time as the position is vacant and a new Director is hired.

(d) C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.

(e) C/FSTs must be independent from any Provider of behavioral health services or any other agency that might create a conflict of interest. C/FSTs that do not have accounting capabilities may contract with a provider as its fiduciary provided the contract safeguards the independence of the C/FST for program direction including budget priorities, satisfaction surveys, findings and recommendations.

(f) The Primary Contractor shall work with the C/FST to establish an annual plan for conducting face-to-face interviews. The plan will include goals such as: the number of interviews to be completed, the levels of care to be surveyed and special focus surveys to address specifically identified special populations. If the C/FST Program identifies barriers to accessing Members to be surveyed, the Primary Contractor will assist to resolve the issue. Priority populations should be given priority for face-to-face interviews.

(g) The Primary Contractor will ensure that the C/FST Program has adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports.

3. **Consumer and Family Satisfaction Team Minimum Requirements**

(a) Persons performing adult satisfaction activities must be, or have been, consumers of behavioral health services, persons in recovery, or family members.

(b) Persons performing family satisfaction activities must include family members of children and adolescents with serious emotional disturbance and/or substance abuse disorders who are receiving or have received behavioral health services in the publicly funded system, and may also include older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.

(c) Family satisfaction team members must have child abuse and criminal history clearances in accordance with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are mandated reporters for child abuse.

(d) The family satisfaction component may be a separate and distinct administrative entity, or may be at least one team of a C/FST Program or one member of a team dedicated to family satisfaction activities.
(e) Young adults (18-22) may be interviewed by either consumer or family satisfaction team members, as appropriate, depending on the services being received.

4. **Conducting Satisfaction Surveys**

Consumer and family satisfaction interviews serve as a means for early identification and resolution of problems related to service access, and timeliness of service delivery, appropriateness of services and recovery and resilience outcomes. Face-to-face interviews afford Members the opportunity to communicate openly with peers on an on-going basis. Additionally, satisfaction surveys assist in determining the level of satisfaction with respect, dignity and hopefulness as integral components of the entire service delivery system. These activities also provide a further check to ensure that the service system is consistent with the principles of recovery in adults, resilience in children and adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The Primary Contractor shall ensure:

(a) Consumer/family satisfaction should be assessed through face-to-face interviews with adult behavioral health service Recipients; children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Interviews should be face-to-face whenever possible however, telephone or mailed surveys may be used if preferred by the Member.

(b) The Primary Contractor shall establish mechanisms in their contract or written agreement to inform the C/FST Program of newly enrolled Members receiving behavioral health services and on-going Members who may wish to participate in satisfaction interviews. The first mechanism below is to be used when member names, addresses and telephone numbers are provided to the C/FST. The second mechanism describes the process if the Primary Contractor does not wish Member names to be provided to the C/FST without Member consent. It is the Primary Contractors responsibility to select the mechanisms for notifying Members about the C/FST Program as follows:

   i) The Primary Contractor periodically provides the names and addresses of Members newly enrolled in mental health services to the C/FST and at least annually updates the list for Members who continue to remain enrolled, and notifies Members receiving drug and alcohol services as stated in 4 (b) ii below; or
ii) The Primary Contractor informs all newly enrolled Members receiving mental health and/or drug and alcohol services about the C/FST Program. The names of members receiving mental health services who wish to be interviewed can be provided to the C/FST without a release of information. Members receiving drug and/or alcohol services must sign a release of information in order for their name, address and telephone number to be provided to the C/FST. A mechanism must be established to provide an opportunity to be interviewed at least annually for Members that remain enrolled in mental health and drug and alcohol services.

(c) Service Providers must provide C/FSTs with comfortable private space for interviews to ensure an environment in which behavioral health consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families feel free to express any concerns they may have.

(d) C/FSTs solicit input from Recipients of behavioral health services and the families of children and adolescents receiving behavioral health services in order that satisfaction and areas of concern can be identified and recommendations for systems improvement can be developed. This can be accomplished through individual and/or group discussions, upon discharge from a service, and as focus groups with behavioral health consumers, persons in recovery, children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families, including visits to programs where members receive their services or to their homes. Family members may be more easily accessed when interviews are conducted by telephone. Information about the C/FST Program is best shared in face-to-face presentation with individuals or groups, however, such methods as videotapes, telephone or written material may also be used.

(e) Some of the C/FST survey questions should address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) the consumer is receiving. The findings of the C/FST shall be organized to identify the Provider, or special population in the case of a focused survey for three purposes: 1) to allow the managed care organization to include C/FST information in Provider profiling, 2) to provide feedback to the individual Provider about their program, and 3) to allow the Primary Contractor (County and/or Managed Care Organization) to direct the Provider to take corrective action to address a Member concern or concerns about the Provider operation or program. The face-to-face surveys and monthly problem solving process ensure action is taken on an ongoing basis and resolution for the Member is timely and responsive. Both the ongoing surveys and the annual survey described in Section B can be used to identify trends that may require system improvement.
(f) The Primary Contractor will identify and request the C/FST to conduct outreach efforts to under-served or un-served groups of consumers and families in order to conduct satisfaction surveys and identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services.

5. **Areas for Consumer and Family Satisfaction Team Observation and Discussion with Recipients of Behavioral Health Services and the Families of Child and Adolescent Service Recipients**

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. The survey tool should allow identification of the Provider(s) and the service(s) provided as well as general satisfaction with the service system. Satisfaction surveys shall include but not be limited to the following areas:

**BH-MCO Related Issues:**
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

**Service Delivery:**
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient

**Treatment:**
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care
Overall Satisfaction:

- Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

DPW may from time to time require specific questions to be added to C/FST satisfaction surveys in order to conduct statewide quality assurance activities.

6. Confidentiality

All employees of C/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services. The contract or written agreement will address confidentiality requirements including the following:

(a) All C/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.

(b) All C/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.

(c) Mental Health Confidentiality: For purposes of the HealthChoices program, C/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. C/FST members must be considered as equal to all other mental health professionals with regard to access to mental health consumers, children and adolescents with serious emotional disturbance and their families. There should be no special written permission required to engage consumers and families receiving mental health, whether in state hospitals or community programs.

(d) Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized
caretaker could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent’s consent before interviewing family members or caregivers.

(e) Drug and Alcohol Confidentiality: A service agreement between the C/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Public Welfare, Joint Commission on Accreditation of Healthcare Organizations, and Single County Authorities for Drug and Alcohol services.

(f) Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider contacting a C/FST Program to provide the name of a person who wishes to be surveyed, a consent to release information form must be signed by the Member requesting their name, address and telephone number be provided to the C/FST Program. A copy of the signed consent to release information form must be retained in the Member’s treatment file and a copy given to the Member and the C/FST. Consent to release information forms for Members receiving drug and alcohol treatment services are not required when the C/FST conducts surveys without receiving the persons name and reports data in the aggregate.

(g) Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment services, regardless of age, must give their written consent for a parent or other family member to be interviewed, or to be present while the Recipient of services is being interviewed.

(h) C/FSTs must be afforded the opportunity to meet with mental health consumers and Recipients of substance abuse services and the family members of child and adolescent service Recipients to describe and explain the purpose and function of C/FSTs.

7. **Problem Identification and Recommendations for Action**

C/FSTs must provide feedback to the Primary Contractor through written quarterly reports and monthly problem resolution meetings that allow for dialogue and review of findings. The Primary Contractor is responsible for timely reports back to the C/FST on specific actions and problem resolution resulting from identified issues, concerns and problems. The contract or written agreement shall identify the process the Primary Contractor will use to resolve problems and address suggestions identified by the C/FST including the following:
(a) Process for problem identification and resolution that includes the C/FST Program, consumers, persons in recovery, parents, adolescents, children, designated county staff, staff of the managed care organization, and advocates as appropriate to the problem identified.

(b) The problem resolution process must include how often problem resolution meetings will occur, with whom, and the responsibilities of all parties (County, C/FST, managed care organization, and Providers). This process will identify actions to be taken by the Primary Contactor if resolution is not reached. There must also be a process in place for responding to urgent matters identified by Members.

(c) The Managed Care Organization sub-contracts with Providers of behavioral health services in their network shall include the timeframe in which the Provider must respond to the recommendations made by the C/FST as directed by the County, Managed Care Organization or the C/FST. Providers of behavioral health services should be required to use C/FST feedback in their quality management program.

(d) The Primary Contractor must provide a timely response to the C/FST on actions taken in response to reported problems and concerns resulting from service Recipient interviews for inclusion in the next quarterly report.

(e) Mechanisms must be in place to address identified trends or system changes that may require the Primary Contractor to study in more depth to understand the issue and resolve. This may include focus meetings on specific topics or collaboration with other involved service systems. The results of these focus studies will be provided to the C/FST for inclusion in their reports.

8. Knowledge, Training and Orientation of Consumer and Family Satisfaction Teams

The Primary Contractor will ensure that C/FST members have both an initial orientation to and on-going training in the following areas:

(a) C/FST members must have basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both for adults and children and adolescents. Persons performing Family Satisfaction activities must also have an understanding of serious emotional disturbance and substance abuse disorders in children and adolescents.

(b) Training for C/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must
include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(c) C/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.

(d) Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.

(e) The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.

9. **Quarterly Reports**

The Primary Contractor shall provide the Department with the C/FST Program’s quarterly report summarizing consumer and family satisfaction findings, as well as improvement actions and system changes implemented by the Primary Contractor in response to those findings. The Primary Contractor shall provide support and direction to the C/FST to ensure the report contains not only the numeric results of surveys conducted but also information about the actions taken in the previous quarter by the Primary Contractor or behavioral health service Provider, trends observed, and other relevant information that can be used by Providers and others about ways to improve treatment and supports.

10. **DPW Annual Review of Consumer/Family Satisfaction Team Programs**

DPW will conduct an annual review of the C/FST program that will include a review of the following:

(a) Results of satisfaction surveys;

(b) Actions taken to resolve identified issues and system changes;

(c) Role and effectiveness of the Primary Contractor in problem resolution and direction to the C/FST program;

(d) Adequacy of the budget, staff, and training opportunities to carry out the requirements of the program;

(e) Role of the fiduciary, if applicable, in supporting the program and financial priorities established by the C/FST program; and

(f) Progress on gaining skills and abilities of the C/FST program to move toward operating as an independent, conflict free, satisfaction program, as applicable.
B. ANNUAL MEMBER SATISFACTION SURVEYS

1. Consumer and Family Satisfaction Annual Mailed/Telephonic Survey

The Primary Contractor is responsible for ensuring that an annual satisfaction survey of a representative sample of persons served by the behavioral health program is conducted by mail or telephonically. The purpose of the Annual Mailed/Telephonic Consumer and Family Member Satisfaction Survey is to determine the extent to which the BH-MCO adult Members and family members of children and adolescents are satisfied with overall BH-MCO operations and services, and to identify areas which need improvement. Surveys are developed and used by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family members of children and adolescents are knowledgeable about and satisfied with the behavioral health program including core functions such as member services as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the Member’s needs and expectations.

(a) Surveys of Recipients of substance abuse services, regardless of age, must be distributed by Providers at service delivery sites in order to protect the confidentiality of persons being surveyed.

(b) A separate survey instrument must be developed for children and adolescent service Recipients and their families.

(c) Findings and resulting recommendations from the survey and consumer/family satisfaction activities are to be incorporated into the Primary Contractor’s ongoing quality management and improvement program.

(d) The County may directly conduct the annual survey or direct the managed care organization, C/FST Program, or another entity that would be conflict free, to conduct the annual survey.

2. Areas Covered by the Consumer and Family Satisfaction Survey

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. Satisfaction surveys shall include but not be limited to the following areas:

BH-MCO Related Issues:
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff
Service Delivery:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family Members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

Overall Satisfaction:
- Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

Miscellaneous:
- Items required by the Department as a result of the Department’s ongoing monitoring and program evaluation.
- Knowledge of and satisfaction with the Medical Assistance Transportation Program
- Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
- Suggestions for improvement

3. Sampling Procedure

The Annual Mailed/Telephonic Consumer and Family Satisfaction Survey must be sent to, or conducted with, a representative sample of behavioral health service Recipients with a statistically valid sampling of Members in the adult priority population groups, family members of child and adolescent service Recipients, and special needs populations, as well as a sampling of Members who filed complaints and grievances. The survey of Members receiving drug and alcohol services must be anonymously distributed through service Providers.
4. **Frequency of Survey and Reporting Results**

A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year. The Consumer and Family Satisfaction Mailed/Telephonic Survey will be conducted at least annually.
## Behavioral HealthChoices
### Data Reporting Requirements*
#### Non-Financial

<table>
<thead>
<tr>
<th>File/Report Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Data Format Transfer Mode Due Date</th>
<th>Reporting Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Monitoring</td>
<td>Reports data needed for transition monitoring, i.e. eligibles, authorizations, denials, grievances</td>
<td>Weekly during first three start-up months, at a minimum</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due close-of-business on Wednesday following reporting week</td>
<td>Requirements &amp; Specifications for Transition Monitoring</td>
</tr>
<tr>
<td>Quarterly Monitoring</td>
<td>Reports data needed for ongoing monitoring, i.e. eligibles, authorizations, complaints, inpatient involuntary admissions, discharges and re-admissions.</td>
<td>Quarterly</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 45 days after end of reporting quarter</td>
<td>Requirements &amp; Specifications Manual for Quarterly Monitoring</td>
</tr>
<tr>
<td>Aggregate Encounter</td>
<td>Reports aggregate data based on claims adjudicated, i.e. consumers, units, dollars, diagnosis, age. Also includes aggregate subcapitation data</td>
<td>Monthly until DPW is satisfied with the accuracy of person-level Encounter data</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after end of reporting month</td>
<td>Aggregate Encounter Reporting Manual</td>
</tr>
<tr>
<td>837 Reporting</td>
<td>Reports each time consumer has an encounter with provider. Format/data based on HIPAA compliant 837 format.</td>
<td>Monthly</td>
<td>ASCII files via FTP: Due last calendar day of 3rd month after the Primary Contractor paid/adjudicated the encounter.**</td>
<td>HIPAA implementation guide and addenda.** PROMISecompanion guides.***</td>
</tr>
<tr>
<td>Alternative Payment Arrangement Reporting</td>
<td>Reports any payment arrangement with a provider other than fee for service.</td>
<td>Varies</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after the end of a payment cycle</td>
<td>Alternative Payment Arrangement file format.</td>
</tr>
<tr>
<td>Complaints and Grievances</td>
<td>Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances</td>
<td>Monthly</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after end of reporting month</td>
<td>Complaint/Grievance Reporting Manual</td>
</tr>
<tr>
<td>Consumer Data. Consumer Registry/Quarterly Status (included in Performance Outcome Management System)</td>
<td>Reports person-specific demographic/clinical data at registry and closure; i.e. birth date, priority group, service request date, independence of living. Reports status &amp; outcome data on priority group consumers, i.e. independence of living, voc/ed, residential moves</td>
<td>Semi-Annually</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after the end of reporting quarter</td>
<td>Performance Outcome Management System Reporting Manual</td>
</tr>
<tr>
<td>MCO Provider File</td>
<td>Reports all providers within the network.</td>
<td>Monthly</td>
<td>ASCII via FTP; Due second Monday of the month</td>
<td>Specifications for MCO Provider File</td>
</tr>
</tbody>
</table>
Behavioral HealthChoices
Data Reporting Requirements*
Non-Financial

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Monthly TSS Services</td>
<td>Report Tracks TSS hours and recipients authorized and TSS hours and recipients paid.</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
<td>Letter to HealthChoices Contractor from Mike Jeffrey dated 1/21/04.</td>
</tr>
<tr>
<td>Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial Log</td>
<td>Reports each time a requested service was denied, as well as any alternatives approved.</td>
<td>Monthly</td>
<td></td>
<td>ASCII</td>
<td>eGovernment Secure Data Exchange; Due 15 days after end of reporting month.</td>
<td>Denial Log Reporting Manual.</td>
</tr>
<tr>
<td>COD Reporting</td>
<td>Reports number of network providers Screening and Assessing for co-occurring disorders as well as prevalence of co-occurring substance abuse and mental health disorders</td>
<td>Annually</td>
<td></td>
<td>Via email</td>
<td>to OMHSAS due 30 days after end of reporting year.</td>
<td>Presentation on 4/4/07 Letter to Advisory Board</td>
</tr>
</tbody>
</table>

*Does not cover financial reporting requirements. The file specifications, formats, data elements and reporting requirements are available in the Proposers’ Library and are subject to change by the Department.

** HIPAA Implementation Guides and Addenda for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania’s PROMISe system.
HealthChoices Behavioral Health Program
Requirements for County Reinvestment Plans

Counties that are successful in becoming the Primary Contractor for the HealthChoices program in their County, or behavioral health managed care organizations (BH-MCOs) under direct contract with the Department of Public Welfare (DPW) are allowed to retain Capitation revenues and investment income that was not expended during the contract year to reinvest in programs and services in their County. These funds, called Reinvestment Funds, must be spent in accordance with a DPW; Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan.

Reinvestment Funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill identified gaps in the treatment system, to test new innovative treatment approaches, and to develop cost-effective alternatives to traditional services that may create cost offsets for In-Plan Services. Reinvestment Funding is one mechanism used to achieve the Commonwealth’s expectation for continuous quality improvement of a comprehensive treatment system that not only supports recovery for persons with mental health, drug and/or alcohol treatment needs, but their families as well. This document refers to both the reinvestment plan and reinvestment plan priorities. The term “plan” refers to the entire reinvestment submission for the contract year. The “reinvestment plan priorities” are the individually named projects submitted with a program description and numbered in priority order.

This document describes the required planning process, financial reporting, allowable expenditures, and the approval process for Primary Contractors to use Reinvestment Funds. These requirements are detailed in the HealthChoices Request for Proposals (RFP), the HealthChoices Agreement, and the Financial Reporting Requirements – HealthChoices Behavioral Health Program document.

Definitions

Affiliate- Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter “Person”), controlled by or under common control with a private sector BH-MCO, including a private sector BH-MCO subcontracting with a county, joinder, or other county grouping, or a private sector BH-MCOs parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five percent (5%) or more of the outstanding ownership interest of the private sector BH-MCO’s or Private Sector BH-MCO’s parent(s), directors and subsidiaries of the private sector BH-MCO, shall be presumed to be Affiliates under the HealthChoices Program. For purposes of this definition, “control” means the possession, directly or indirectly, or the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interest, or
by contract or otherwise, including but not limited to the power elect a majority of the
directors of a corporation or trustees of a trust, as the case may be.

Capitation – A fee DPW pays periodically to a Primary Contractor for each recipient
enrolled under an Agreement for the provision of covered In-Plan Services, whether or
not the recipient received the services during the period covered by the fee.

Discretionary Funds (Profit) – Capitation payments and investment income that are not
expended for purchase of services for plan Members (In-Plan, Supplemental, or cost-
effective alternatives), administrative costs, Risk and Contingency, or reinvestment.

In-Plan Services – Services which are included in the HealthChoices behavioral health
Capitation rate and are the payment responsibility of the Primary Contractor.

Non-Medical Services – Costs that enhance service systems or service delivery but are not
medical services.

Primary Contractor – A successful Proposer or its successor approved by DPW.

Private Sector BH-MCO – A Commonwealth licensed MCO which has contracted with
DPW or subcontracted with County government to manage the purchase and provision of
behavioral health services under the HealthChoices Program.

Related Parties – Any Affiliate that is related to the Primary Contractor or subcontracting
BH-MCO by common ownership or control (see definition of “Affiliate”) and:
   (1) Performs some of the Primary Contractor of subcontracting BH-MCO’s
       management function under contract or delegation; or
   (2) Furnishes services to Members under written agreement; or
   (3) Leases real property or sells materials to the Primary Contractor or
       subcontracting BH-MCO at a cost of more than $2,500 during any year of
       a HealthChoices Behavioral Health Agreement with the Department.

Reinvestment Funds – Capitation revenues from DPW and investment income which are
not expended during an Agreement year by the Primary Contractor for purchase of
services for Members, administrative costs, Risk and Contingency Funds, and equity
requirements, but may be used in a subsequent Agreement year to purchase start-up costs
for In-Plan Services, development or purchase of Supplemental Services or non-medical
services, contingent upon DPW prior approval of the Primary Contractor’s reinvestment
plan.

Risk and Contingency Funds – PMPM Capitation funds received by the Primary
Contractor pursuant to this Agreement, which are not expended on services (In-Plan,
Supplemental, or Cost-Effective Alternatives) or administrative functions and which are
in excess of the Equity Reserve required to be maintained under this Agreement. Risk
and Contingency Funds do not include Reinvestment Funds or funds designated in a
reinvestment plan submitted to DPW.
Supplemental Services – MA eligible mental health services and drug and alcohol services purchased in lieu of or in addition to an In-Plan Service.

A. Planning for Reinvestment Funds

**Involvement of Stakeholders**

1. The planning process must include and document the involvement of consumers, families (including families of children and adolescents), persons in recovery, MH/MR and Single County Authorities (SCA), and as appropriate, County Commissioners and local legislators.

2. In order for stakeholders to provide informed feedback about options for Reinvestment Funds the County and BH-MCO should present the results of data analysis performed to document utilization trends, unmet needs, populations served, outcomes achieved by the HealthChoices program to date, etc. as part of the reinvestment plan planning process.

3. Stakeholders must be involved at all stages of the planning and decision making process. Evidence of their involvement and feedback must be summarized as part of the plan submission.

4. Counties may choose to incorporate planning for Reinvestment Funds and receiving stakeholder input as part of the County Mental Health Planning process.

5. Preliminary reinvestment plans should be discussed with the OHMSAS Field Office for input regarding planned use of funds prior to submission.

**Timeframes for Submission and Approval**

1. The timeframes for submission and approval are provided as approximate dates. The dates provided are the outside dates for when submission is required. Primary Contractors may submit plans prior to the completion of the audit using estimates of the Reinvestment Funds available. Submission timeframes are calculated from the beginning and ending dates of the annual contract. Dates for review and approval may vary depending on any additional information or clarification needed. The review process is summarized below, and detailed steps are provided in Attachment 1.

2. Plans for Reinvestment Funds are submitted annually based on the HealthChoices contract year.

3. Draft plans are submitted to OMHSAS Field Office for review and comment once the amount of Reinvestment Funds are identified and confirmed by OMHSAS. This should be no later than the first day of the ninth (9th) month after the end of the contract year.

4. OMHSAS Field Office provides written feedback to the Primary Contractor within 2 weeks after receiving the draft plan.

5. Final reinvestment plans are to be submitted within 30 days of receiving OMHSAS feedback, which should occur no later than the first 2 weeks of the tenth (10th) month after the end of the contract year.

6. The Reinvestment Review Committee reviews final reinvestment plans. If there are no questions, written approval/denial will be provided within 2 weeks after...
the plan submission. If there are questions, the questions are provided to the Primary Contractor. Once the Primary Contractor responds to the questions by providing the requested additional information and/or submitting a revised plan, written approval/denial will be provided within 2 weeks.

7. Primary Contractors should begin implementing their approved reinvestment plan when they receive written notification that the plan is approved and when the funds to support the plan have been deposited into a restricted account as required (within 30 days of plan approval).

8. If Reinvestment Funds from a subsequent year are intended to be used to continue funding a previously approved reinvestment plan priority, the Primary Contractor should submit the previously approved plan with updated financial information related to the request for continuation funding. There should be evidence that stakeholders continue to support the plan priority and evidence of the benefit from implementing the priority. OMHSAS will approve such plans without additional review to ensure Reinvestment Funds can be spent without interruption for the years in which the county intends the funds to be spent.

9. When additional funds are identified, plans must be submitted no later than 12 months from the date additional Reinvestment Funds are identified. The new plans will be reviewed at the time they are received following the same process described above. Exceeding this timeframe for submission may result in the DPW recovery of these funds.

B. Identification of Reinvestment Funds

1. Primary Contractors should confirm with OMHSAS, the amount of Reinvestment Funds available. Written confirmation should be received, in order to meet the above timeframes, by the middle of the (8th) month after the end of the contract year. Confirmation of funds available should occur before the draft reinvestment plan is submitted. It is understood that the amount of reinvestment money available is subject to change based on future reconciliation.

2. For reinvestment purposes only, adjustments made to prior year available funds two (2) years after submission of the contract audit will be applied to the most recent audited contract year.

3. Funds that would otherwise be available for reinvestment, but are being proposed for County Risk and Contingency, when the County is the Primary Contractor, must be identified and approved by OMHSAS. The County must submit a written request to OMHSAS for approval of Risk and Contingency Funds stating the rationale for the request prior to its letter confirming the amount of reinvestment available. A written request for approval to use Risk and Contingency Funds for reinvestment purposes must be submitted to OMHSAS and approved prior to the submission of a reinvestment plan.

4. A reinvestment plan must be submitted for approval within twelve (12) months of the time additional funds are identified for reinvestment.
C. Guidance on the Use of Reinvestment Funds

Allowable Uses for Reinvestment Funds
1. Start-up costs for In-Plan Services including payment of service costs during capacity building;
2. Development and/or purchase of Medical Assistance (MA) eligible Supplemental Services that are in-lieu of or in addition to;
3. Behavioral health services that are not MA eligible (non-medical) such as purchase or renovation of a facility, vocational services, housing development, rental subsidy, respite, etc.; and
4. Training and consultation that is required to implement a new service or support for MA eligibles.

- Expenditures must be consistent with the conditions of the Center for Medicare and Medicaid Services (CMS) waiver, the HealthChoices RFP and Agreement.
- DPW will provide a listing of MA eligible Supplemental Services. Primary Contractors may request approval of a new MA eligible Supplement Service.

Reinvestment Funds Cannot be used for:
1. Incentives payment to a BH-MCO.
2. On-going payment of In-Plan Services.
3. Administrative costs such as medical management, quality management activities, outcome studies, etc.
4. Training not connected to the development of a specific service or program (see Allowable Expenditures for Training) detailed below.
5. Transportation costs that are available under the Medical Assistance Transportation Program (MATP).
6. Services targeted primarily for non-Medical Assistance (MA) eligible persons.
7. Expenditures that do not comply with the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Allowable Expenditures for Training
Training is an important component of any new service. In developing a budget as part of a reinvestment plan, the training component should be identified in the overall budget of the service. Following are two (2) options that can be used for inclusion of training costs in a reinvestment plan:

A. Training as Part of the Development of a New Service
The training must be tied to a new service and not a stand-alone budget item. For example, if the Primary Contractor has determined that there is a need for a Mental Illness Substance Abuse (MISA) program, Reinvestment Funds could be allocated to cover the costs of training for the implementation of this program. However, if the Primary Contractor decided that they would like to train all County staff in MISA “best practice,” the Primary Contractor would
need to use administrative dollars to fund this training since it is not tied to a specific program developed to provide services targeted for MA eligible consumers.

B. Training Built into the Service Rate
As part of the development of new MA funded services, (such as Intensive Case Management (ICM), Family-based, etc.) which were under the auspices of OMHSAS, training was built into the overall rate setting methodology. This practice acknowledged that training is an important component of these new mental health services. Likewise, the Primary Contractor may build training costs into the payment rate as part of their reinvestment plan, as long as it is tied to a specific program that is targeted to serve the MA eligible population.

Allowable Expenditures for Purchase, Renovation and Fixed Assets
1. The reinvestment plan must address additional information specified in the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5) when a plan priority includes these Non-Medical services or supports. These guidelines specify the additional information that must be included in the reinvestment plan priority submitted and in the agreement entered into between the Primary Contractor and Subcontractor. These include:
   A. Additional areas that must be addressed in the reinvestment plan description regarding ownership, analysis of the need for Non-Medical Services, availability of an on-going revenue source, etc.
   
   B. A detailed budget of the costs associated with purchase of a facility or property, renovation, fixed assets, personnel, operating expenses, etc. must be submitted following the guidelines in Attachment 5.
   
   C. The County/Provider Agreement should ensure that if the property is sold that any proceeds from the sale would be returned to the County. In this case a new reinvestment plan for these funds must be submitted within twelve (12) months or the funds will be considered Discretionary Funds which must be returned to the Department.
   
   D. Costs for Non-Medical Services are not considered in the HealthChoices rate setting process and DPW has no obligation to continue to fund priorities that were approved as one-time expenditures for the purchase or renovation of a facility.
D. OMHSAS Plan Parameters

Format for Submission of Reinvestment Plans
1. The reinvestment plan must be submitted in accordance with OMHSAS established parameters.
2. A standardized format for submission of both the draft and final reinvestment plan is provided in Attachment 3. Each reinvestment plan priority for the contract year must be numbered in priority order and must be submitted on a separate form using this format. **The same priority numbers must always be used on all reports to facilitate tracking.** One (1) set of budget forms must be submitted listing each reinvestment plan by priority number (Attachment 4).
3. The reinvestment plan title is to include the Primary Contractor name and contract year from which the funds are identified as available for reinvestment.
4. The reinvestment plan priority format identifies the: County; the date of submission; the type of service to be funded In-Plan-start-up, Supplemental-In-Lieu of, Supplemental- In Addition to, or Non-Medical Only); indicate if it is a new, or continuation, and indicate the numeric priority assignment of the reinvestment plan.
5. Reinvestment plan priorities can include expenditures over several years, with the exception of In-Plan Start-up that should be completed within one year.
6. Each reinvestment plan priority must state the contract years in which Reinvestment Funds will be spent. Primary Contractors should ensure the dates for expenditure are realistic to avoid requests for extensions.
7. When determining the contract year in which the reinvestment plan priority funds will be spent, the County should consider the time it will take to accomplish the plan priority and the date of OMHSAS approval. If the time to approve the plan priority was delayed, the final date for spending may need to be adjusted.
8. Expenditures for a reinvestment plan priority cannot be incurred until the effective date of the OMHSAS approval letter.
9. OMHSAS reserves the right to request additional information, if necessary, in order to approve a reinvestment plan priority.

Target Population
1. The reinvestment plan must identify that it is targeted for the unmet or under-met needs of mental health and drug and alcohol MA eligibles.
2. It is understood that some non-MA eligible consumers may receive services in a program established to target MA eligible members. The reinvestment plan must include an estimate of the number of non-MA eligible clients to be served.
3. Reinvestment plan priorities must identify the priority populations to be served.
4. Describe the population that is targeted for the reinvestment plan priority, e.g. adults with serious mental illness, adolescents with drug and alcohol treatment needs, etc. Include an estimation of the number of persons to be served by the reinvestment plan priority.
Description of Program or Service
1. Reinvestment plans must include a detailed narrative description of each program or service that is consistent with, and supports the definition of the service as being either In-Plan start-up, Supplemental Services- In-Lieu of Supplemental-In-Addition to; or Non-Medical Only.
2. Describe the program or service to be funded by the reinvestment plan priority and why this service or approach is expected to improve the health outcomes for the persons targeted.
3. If a Primary Contractor is requesting the approval of a new MA eligible Supplemental Services, identify the services or services that are expected to generate cost offsets once the Supplemental Service is available.

Description of Fund Expenditures
1. Provide a brief summary of what the reinvestment plan priority will fund.
2. Each reinvestment plan priority must contain a description of the major budgeted items (personnel, equipment, operational costs, etc.) and cost associated with each item.
3. If the reinvestment plan priority is funding start-up costs for an In-Plan Service, list the specific start-up costs expenditures that will be funded, and the length of time start-up costs will be required e.g. 3 (three) months of staff salaries, staff training, etc.
4. Requests for start-up costs for In-Place Services that will extend beyond the first year of the plan implementation may be considered if sufficiently justified.
5. Identify how the reinvestment plan priority will be financed for continuation once Reinvestment Funds have been expended, if applicable.
6. Reinvestment plan priorities with requests for Non-Medical facility, land or property purchase and/or fixed asset expenditures require submission of the specific information outlined in Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Data Analysis Supporting Request
1. Include a summary of the data analysis that supports why the target population has been chosen and why the specific service has been chosen for Reinvestment Funds. Identify the number of HC members in the target population.
2. Identify the outcomes to be achieved by the service and the data to be collected to measure the outcomes.

Description of Stakeholder Involvement in Decision Making
1. Requests must summarize stakeholder involvement in the planning and decision making process for each request.
2. It is expected that stakeholders will be provided information about the outcomes achieved by the HealthChoices program to date. This might include the current strengths and opportunities for improvement as seen by the County and BH-
MCO. Such information will allow stakeholders to provide informed feedback about priorities for Reinvestment Funds.

Reinvestment Budget Forms
1. Four (4) budget forms must be submitted which break out costs based on eligibility category for HealthChoices recipients, MA recipients, Non-MA recipients and total expenditures. One set of budget forms is to be completed, listing each reinvestment plan priority submitted (Attachment 4).
2. Primary Contractors should use their best estimates to determine the number of clients in each of these three (3) categories. It is understood that members move in and out of eligibility categories.

E. Financial Requirements for Reinvestment Funds
1. Primary Contractors must place Reinvestment Funds in a separate restricted account. Bank statements for the account must be submitted monthly. Bank statements are to be reconciled monthly.
2. Reinvestment Funds can be deposited when identified, but must be placed in a restricted account within 30 days of the OMHSAS written approval of the reinvestment plan(s).
4. Report #12 must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected in this report.
5. A separate report is required for each of the seven (7) categories of aid included in the HealthChoices program, e.g. TANF, Healthy Beginnings, SSI & Healthy Horizons with Medicare, etc.
6. Expenses are to be reported based on actual category of aid. To the extent that this is not possible and the expenses must be allocated, then an allocation methodology will need to be submitted and receive prior written approval from DPW.
7. If Reinvestment Funds from more than one contract year are being utilized, a separate set of reports must be filled out for each contract year’s Reinvestment Funds.
8. Interest earned from the reinvestment account must be reported on Report #12. Expenditures of interest earned must be consistent with an approved plan.
9. Funds are withdrawn from the reinvestment account in accordance with a plan approved by OMHSAS. No funds can be distributed, or expenditures incurred, prior to the date of the OMHSAS approval letter.
10. Primary Contractors must return any unexpended Reinvestment Funds to DPW within six (6) months of the date by which funds were approved to be spent, unless the timeframe for expenditure of these funds was extended by OMHSAS. After that time, unexpended Reinvestment Funds must be returned to DPW.
11. If a contract is terminated, Counties can retain funds remaining as part of an approved reinvestment plan. If the Primary Contractor is a BH-MCO the funds must be returned to DPW.

12. Funds identified in a reinvestment plan submitted to DPW, but on which DPW has not taken a positive or negative action, are not considered Discretionary Funds.

F. Modifications to Approved Reinvestment Plans

1. Proposed changes or modifications to an approved reinvestment plan priority must be submitted in writing. Written confirmation of approval of a change will be issued by OMHSAS within the approval timelines described below.

2. Changes may include a request to: extend the timeframe for expenditure of funds, revise the approved program, withdraw an approved plan and propose a new plan for use of the funds, or change the amount of expenditure when approval of such a change is required.

3. A request for an extension of an approved reinvestment plan (numbered by priority) must be received 45 days prior to the end of the final contract expenditure year stated on the OMHSAS reinvestment approval letter and must indicate the reason extension. OMHSAS will provide a written response to a request for extension within 2 weeks.. Failure to meet this 45-day requirement may result in DPW’s recovery of these funds.

4. If program or service plan modifications are requested after a reinvestment plan priority has been approved by OMHSAS, the Primary Contractor must use this same format (Attachment 3) to submit a request for change. Stakeholder involvement, and documentation of such, must occur if a new reinvestment plan priority is being proposed to substitute for a previously approved priority.

5. Any revisions to the amount approved for an individual reinvestment plan priority which is the greater of twenty-five percent (25%) or $50,000 for the priority being revised, must be approved by OMHSAS in advance. Examples include:
   a. A plan has been approved for $100,000. The County wishes to decrease the plan by $40,000. This change could be made without approval since the greater of 25% or $50,000 has not been exceeded, or;
   b. A plan is approved for $1M. The county wishes to increase the plan by $300,000. This change would have to be approved since the change is the greater than 25% (25% equals $250,000).

6. The Reinvestment Report-Budget forms (Attachment 4) will be used to track approved changes for expenditures and reinvestment plan priorities from a contract year.

G. County Annual Report on HealthChoices Reinvestment Plans

1. Submission of an Annual Report on HealthChoices Reinvestment Plans for approved reinvestment plans from the previous contract year and those plan
priorities that continue to be funded with reinvestment dollars is required. The annual report of Reinvestment Funds is to include a program summary for each reinvestment plan priority that continues to be funded with reinvestment dollars.

2. The Annual Report on HealthChoices Reinvestment Plans is due on the last day of the thirteenth (13th) month from the end of the contract year. The required format for submission is attached (Attachment 7). An updated budget is required to be submitted annually.

3. OMHSAS provides a summary of all approved reinvestment plans to stakeholders. The summary is published in the OMHSAS HealthChoices Behavioral Health Program Annual Report.

4. A summary of the Annual Report on HealthChoices Reinvestment Plans is also distributed to stakeholders.
<table>
<thead>
<tr>
<th>Step #</th>
<th>Responsible Entity</th>
<th>Step Description</th>
<th>Timeframe</th>
<th>Targeted Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contractor</td>
<td>HealthChoices Contract Audit Completed</td>
<td>4.5 months after contract year end</td>
<td>Middle of 5th month after contract year end</td>
</tr>
<tr>
<td>2</td>
<td>PHHS Comptroller</td>
<td>Audit Acceptance</td>
<td>2 months</td>
<td>Middle of 7th month after contract year end *Option to submit based on est.</td>
</tr>
<tr>
<td>3</td>
<td>Contractor</td>
<td>Identifies amount of reinvestment funds available</td>
<td>1/2 month</td>
<td>End of 7th month after contract year end</td>
</tr>
<tr>
<td>4</td>
<td>Contractor</td>
<td>Confirm with OMHSAS amount of reinvestment funds available. Submit draft</td>
<td>1 month</td>
<td>First day of 9th month after contract year end</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reinvestment plans to OMHSAS Field Office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>OMHSAS Field Office</td>
<td>Provide feedback to Contractor on draft plans</td>
<td>2 weeks</td>
<td>Second week of 9th month after contract year end</td>
</tr>
<tr>
<td>6</td>
<td>Contractor</td>
<td>Submit final reinvestment plans to OMHSAS Field Office</td>
<td>1 month</td>
<td>Second week of 10th month after contract year end</td>
</tr>
<tr>
<td>7</td>
<td>OMHSAS, BOQM</td>
<td>Distribute plans to DPW Reinvestment Review Team</td>
<td>Steps 7,8, &amp; 9</td>
<td>Last week of 10th month after contract year end</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 weeks</td>
<td></td>
</tr>
<tr>
<td>8-9</td>
<td>DPW Reinvestment Review</td>
<td>Identifies any additional information needed or approves if no additional</td>
<td>Same as Step 7</td>
<td>Same as Step 7</td>
</tr>
<tr>
<td></td>
<td>Team</td>
<td>information is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OMHSAS Field Office</td>
<td>Provides feedback on final plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>OMHSAS Field Office</td>
<td>Prepares summary of Steps 10, 11, 12</td>
<td>Steps 10, 11, 12</td>
<td>First week of 11th month after contract year end</td>
</tr>
<tr>
<td>Step</td>
<td>Task</td>
<td>Timeframe</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>OMHSAS, Director Eastern or Western Operations</td>
<td>Approves summary and final recommendation after receiving County responses received. Preparises draft approval letter in 1 week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>OMHSAS, Director Eastern or Western Operations</td>
<td>Prepares final approval letter for BOQM Directors signature Same as Step 10 Same as Step 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>OMHSAS, Director BOQM</td>
<td>Sends final approval letter to County Same as Step 10 Same as Step 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Contractor</td>
<td>Begins implementation when approval letter is received and funds have been deposited 30 days 12th month after the contract year end</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: OMHSAS approval timeframes begin when the reinvestment plan or requested plan priority revisions are received from the County.
Date
County MH/MR Administrator

Dear Administrator:

The _______ County HealthChoices reinvestment plan for funds generated during calendar year ____ has been approved. Acceptance of the following initiatives is confirmed.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Budget Amount</th>
<th>In-Plan-Start-up, Supplemental, Or Non-Medical</th>
<th>Contract Expenditure Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuation of Funding for Community Treatment Teams</td>
<td>$600,000</td>
<td>Supplemental</td>
<td>2002 – 2003</td>
</tr>
<tr>
<td>Priority 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Rehabilitation Services</td>
<td>$400,000</td>
<td>Supplemental**</td>
<td>2002 – 2003</td>
</tr>
</tbody>
</table>

HealthChoices reinvestment funds need to be kept in a separate, restricted bank account and statements for the account must be submitted to the Department each month. Funds must be deposited no later than 30 days after the date of this approval. Also, an annual report on the use of reinvestment funds during _____ will be due on ____________.

[Note: Plans that contain Bricks and Mortar will be annotated with two asterisks and will include the following statement: “**The County reinvestment plan submission is in...”]

Example
compliance with the DPW requirements as stated in the Review and Approval Guidelines for Reinvestment Plans that Provide Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets. The HealthChoices reinvestment funds are one-time only funds and start-up costs of these services are not considered in the HealthChoices rate setting process. The Department of Public Welfare has no obligation to continue to fund services approved for this reinvestment plan.

Reinvestment plans should be implemented in accordance with the approved timeframes. Any delay in implementing the plan should be communicated to OMHSAS. The monitoring of HealthChoices reinvestment funds will be discussed during monthly HealthChoices monitoring meetings. However, if you have questions or concerns that require immediate attention, please be in contact with your Monitoring Team leader or Community Program Manager.

Sincerely,

Director, Bureau of Operations and Quality Management
**HEALTHCHOICES REINVESTMENT PLAN PRIORITY**

County_______________________________

Reinvestment Plan from contract year_______________ Date of Submission______________

Name of Service______________________    New Plan_______ Continuation Plan_________

<table>
<thead>
<tr>
<th>Reinvestment Service or Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Plan Start-up _____</td>
</tr>
<tr>
<td>Non-Medical Only _____</td>
</tr>
<tr>
<td><strong>Supplemental – In Lieu of ____</strong></td>
</tr>
<tr>
<td>Approved ____ Procedure Code_____</td>
</tr>
<tr>
<td>Newly Proposed____</td>
</tr>
<tr>
<td>Budget a. Clinical*____</td>
</tr>
<tr>
<td>Budget b. Operating**_____</td>
</tr>
<tr>
<td>One-time only_____</td>
</tr>
<tr>
<td><strong>Supplemental – In Addition to ____</strong></td>
</tr>
<tr>
<td>Budget a. Clinical* ____</td>
</tr>
<tr>
<td>Budget b. Operating** ____</td>
</tr>
</tbody>
</table>

Priority _____ of _____ submitted Year(s) in which funds are to be spent _________

**Target Population:** (MA eligible target population, population characteristics, number people served annually)

**Description of Program or Service:** (Describe program, for: In-Plan start up- under one year. Indicate service is to be licensed; Supplemental In-Lieu of- why service is a cost effective alternative, staffing FTEs/qualifications; Children’s Supplemental requires BHRS program exception application; Supplemental- In Addition to – why expected to be cost effective or appropriate but not cost effective, staffing FTEs/qualifications; and Non-Medical Only- used when all costs are non-medical)
**Description of Fund Expenditures:** (Narrative identifying major budgeted items for clinical and operating expenses and total costs. Identify on-going funding source for program/services. Provide Attachment 5 information as applicable).

**Clinical Costs*** – Narrative and major budgeted items, includes personnel and benefits

**Operating Costs*** – Narrative and major budgeted items, includes travel, telephone, office supplies, fixed assets, facility purchase, etc. Complete Attachment 5 below if applicable.

**Facility or land Purchase or Renovation:** (Attachment 5: Summarize what is being purchased/renovated and ownership arrangement including who owns title. Indicate agreement for disposal of assets upon sale.)

**Fixed Assets:** (Identify fixed assets to be purchased - vehicles, computers, furniture, equipment, etc. Indicate County Code for purchasing will be followed for items requiring competitive bid.)

**Data Analysis and Expected Outcomes:** (Identify number of HC members in target population, describe unmet or under-met needs, what is expected to be achieved by the service and data to be collected to measure outcomes. For Supplemental In-Lieu of services identify the service from which cost offsets will be achieved.)

**Stakeholder Involvement in Decision Making:** (Stakeholder participation summarized and demonstrated support)
Instructions for Completing the Reinvestment Budget Form
(Initial Budget Submission and Revisions):

The HealthChoices reinvestment plan must include a budget form. It is understood that adjustments to IBNRs, interest, and other items may impact the amounts available. Changes to the amount available and the corresponding budget should be handled as follows:

The initial budget submission should be included with the reinvestment plan and should reflect the exact amounts specified in the reinvestment plan. These amounts should be shown in the “Initial/Previous Budget” column.

Subsequent to the initial budget submission, revisions to the budget must be submitted as follows:

- An updated budget must be submitted with the annual reinvestment update.
- If a change is being proposed to any item within the budget, approval must be given by OMHSAS for the change if it is greater than 25% of the current priority amount or $50,000, whichever is higher. The request for approval must include a revised budget reflecting the proposed changes.
- Any changes due to IBNR adjustments or interest earned since the last budget was submitted should be reflected in the “Revision Amount” column.

Anytime revisions to the budget are being submitted, the most recent budget amounts should be reflected in the “Initial/Previous Budget” column.

When reporting actual reinvestment expenditures on Financial Report #12, the budget amounts should reflect the most recent budget amounts submitted.

County – The County HealthChoices Behavioral Health program for which the reinvestment budget is being submitted.

Date – The date the budget form is being prepared.

Reinvestment Funds from – The contract year that the reinvestment funds are applicable to.

Category of Eligibility – There are four separate forms:

- HealthChoices Recipients – provide amounts that will be targeted to individuals who are enrolled in the HealthChoices Behavioral Health program.

- MA Recipients – provide amounts that will be targeted to individuals who are eligible for medical assistance benefits but NOT enrolled in the HealthChoices Behavioral Health program.

- Non-MA Recipients – provide amounts that will be targeted to individuals who are not eligible for medical assistance benefits.
Total – provide totals for amounts provided on individual forms.

**Allocations/Contributions** – Indicate the amount anticipated to be available.

**Investment/Interest Income** – Indicate an estimate of any interest to be earned over the course of the reinvestment spending period. This line item cannot be $0; an estimate **must** be provided.

**Total Available** – Add Allocations/Contributions and Investment/Interest Income.

**Reinvestment Services (Identify)** – List each reinvestment plan item, along with the specific budget amount. Please use the same description and amount used in the reinvestment plan.

**Total Reinvestment Services** – Sum of the individual reinvestment services.

**Remaining Balance** – Allocations/Contributions plus Investment/Interest Income minus Total Reinvestment Services.
Reinvestment Funds from _______________________

Category of Eligibility - HealthChoices Recipients

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment/interest income</td>
<td></td>
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</tr>
</tbody>
</table>

**TOTAL AVAILABLE**

Less: Approved distributions for:

<table>
<thead>
<tr>
<th>Reinvestment Services (Identify)</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**TOTAL REINVESTMENT SERVICES**

**REMAINING BALANCE**

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation must be provided for all budget revisions, regardless of the amount.*
Reinvestment Funds from ________________

Category of Eligibility - __ MA Recipients __

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
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<tbody>
<tr>
<td>Allocations/contributions</td>
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<td>TOTAL AVAILABLE</td>
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<td>Less: Approved distributions for:</td>
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<tr>
<td>Reinvestment Services (Identify)</td>
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<td>TOTAL REINVESTMENT SERVICES</td>
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<tr>
<td>REMAINING BALANCE</td>
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</tbody>
</table>

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306
Prepared by OMHSAS /DMFR
Reinvestment Funds from _______________________

Category of Eligibility - ___Non-MA Recipients____

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Investment/interest income</td>
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<tr>
<td>TOTAL AVAILABLE</td>
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</tr>
<tr>
<td>Less: Approved distributions for:</td>
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<tr>
<td>Reinvestment Services (Identify)</td>
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</table>

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306                          Prepared by OMHSAS /DMFR
Reinvestment Funds from ______________________

Category of Eligibility - ____ Total ____

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
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<tbody>
<tr>
<td>Allocations/contributions</td>
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</tr>
<tr>
<td>Less: Approved distributions for:</td>
<td></td>
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</tr>
<tr>
<td>Reinvestment Services (Identify)</td>
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<tr>
<td>TOTAL REINVESTMENT SERVICES</td>
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</tr>
<tr>
<td>REMAINING BALANCE</td>
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</tr>
</tbody>
</table>

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR
Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets

All reinvestment plan priorities containing costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and/or purchase of fixed assets must adhere to these Reinvestment Plan Guidelines and applicable provisions of the local County Code.

Reinvestment Plan Submission:
Conditions that apply to reinvestment plan priorities that contain costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and or purchase of fixed assets are:

1. Primary purpose of the reinvestment plan priority must be to serve MA eligibles with mental health and/or drug and alcohol treatment service needs.

2. The reinvestment plan priorities must contain a statement of the rationale for the development of the program and related capital costs.

3. The reinvestment plan priority must explain the financial strategy for acquiring the property, facility or vehicle and why that method is cost effective. Identify whether the facility/vehicle will be purchased or leased or will facility costs be built into the service rate.

Each County’s Housing Plan will describe the County’s housing capital development strategy and why acquisition by a housing organization is cost effective from a housing finance perspective.

4. The reinvestment plan priority must summarize the ownership arrangement between the County and provider and specify the party that holds title to fixed assets. Identify related parties when there is common ownership. Provide a detailed data analysis supporting the request as part of the reinvestment plan. The data analysis must support the need for the project proposed. The analysis should include, for example, analysis of the provider network demonstrating a gap in service, rationale for cost effectiveness of the purchase, description of underserved target population to be served, etc.

5. The County may enter an agreement to provide capital resources with a qualified housing organization in exchange for long term use restrictions. The ownership arrangement for any capital development for supportive housing should identify the property to be acquired or replaced, number of units within the overall development that the county will have access to over a specified period of time, how consumer access will be assured, how the county will be reimbursed or be assured use restrictions in the event the property goes into foreclosure. Rental
subsides can be considered in exchange for investment based on a financial analysis that the exchange is of like or greater value.

6. The reinvestment plan priority must include a budget in sufficient detail to demonstrate how the amount identified in the reinvestment plan priority request was determined. This should include budgeted items (e.g. personnel, equipment, operating costs, transportation, repairs, etc.) and associated costs as well as any pertinent assumptions.

7. The reinvestment plan priority must contain information about the source of operating funds for the continuation of the program or service after one-time reinvestment plan funds are expended.

For housing development plans, identify the number of units that will be available for a specified period of time.

8. Purchase of vehicles is not permitted for transportation to MA services of MA eligible members otherwise served by the Medical Assistance Transportation Program (MATP).

County-Provider Reinvestment Plan Agreement:
Any agreement entered into between the County and a provider for the purpose of implementing a reinvestment plan priority, which contains costs for facility or real estate purchase, renovation, vehicle acquisition, and/or purchase of fixed assets, must:

1. Be reduced to writing

2. Be targeted to Medical Assistance eligibles with mental health and/or drug and alcohol service needs.

3. Assure that the acquisition or renovation is likely to be used in the HC program for at least five years and be subject to specified disposition requirements.

4. Identify any related parties and the relationship of the related parties regarding the accomplishment of the reinvestment plan.

5. Specify ownership rights, use of the facility, and the process for disposition of fixed assets in the event a sale should occur.

Housing plans will address how restrictions of use will be passed on to future buyers in the event of property transfer for housing development by housing organizations.
6. In the event of a sale, proceeds from the sale are to be returned to the County HealthChoices program for reinvestment in programs or services for MA eligible members. This provision is not applicable to housing development plans.

7. Specify the accounting method to be used in expensing, depreciating or amortizing costs. This provision is not applicable to housing development plans.

8. Require maintenance, repair and insurance of fixed assets.

   In the case of a facility being purchased for housing, the County should specify the required maintenance and insurance of fixed assets. To ensure a property is maintained, the County may require or conduct periodic inspections to ensure compliance with HUD’s Housing Quality Standards (HQS). Failure of inspection may trigger foreclosure or other actions as specified by the County. The County should be named on the insurance of fixed assets to order for the County to be notified if coverage ceases and failure to maintain insurance of fixed assets can also trigger foreclosure or other action as specified by the County.

9. Require competitive bidding or written estimates as required by County Code or prudent business practices.

10. Be reviewed and approved by the County Solicitor and/or other appropriate County official (e.g. MH/MR legal counsel) to ensure compliance with these Reinvestment Plan Guidelines and applicable County Code provisions.

11. Contain a budget that details the costs associated with the facility renovation or purchase of fixed assets as submitted in the County’s reinvestment plan priority. This provision is not applicable to housing development plans.
3.12 Report #12 - Reinvestment Report

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but must be placed in a restricted account within 30 days of the OMHSAS written approval of the County’s reinvestment plan(s).

IMPORTANT NOTE: The services reported on this report should NOT be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year’s capitation revenue.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. A separate report must be provided for each of the following categories of aid:

1. TANF
2. Healthy Beginnings
3. SSI w/ Medicare & Healthy Horizons
4. SSI w/o Medicare
5. Federal GA
6. GA CNO
7. GA MNO (all age groups combined)
8. Other (non-HealthChoices recipients or non-identifiable recipients)
9. Total (total of the eight categories above)

A methodology for allocating costs that are not attributable to a specific category of aid must be submitted and approved by DPW prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year’s reinvestment funds.

The count of unduplicated recipients should be unduplicated by each individual reinvestment service and should reflect unduplicated recipients on a contract to date basis.

The Prior Period Balance is the reinvestment account balance as of the last day of the prior calendar month for the “Current Period” column; the reinvestment account
balance as of the last day of the prior year for the “Year to Date” column; and $0 for the “Contract to Date” column.

*Allocations/contributions* are funds transferred into the reinvestment account.

*Investment Revenue* is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.

*Approved Distributions* are funds withdrawn from the reinvestment account in accordance with the DPW-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DPW prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported must be disclosed in detail in the footnotes to these reports.

*Ending Balance* is the reinvestment account balance as of the end of the last day of the calendar month.

*The Budgeted Amount* column should reflect the amounts and services contained in the DPW-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DPW for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans. Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as “Other”.

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or $50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in the footnotes to the reports.

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month’s report. The Department reserves the right to request additional documentation.
Reinvestment Report Form

Statement as of: ____________________________________________________________________________ (Reporting Date)
County: ____________________________________________________________________________________ (County Name)
Reported By: ______________________________________________________________________________ (Reporting Entity)
For: ________________________________________________________________________________________ (Year of Reinvestment Funds)
Rating Group: _______________________________________________________________________________ (Rating Group)

<table>
<thead>
<tr>
<th>Reinvestment Account Activity</th>
<th>Unduplicated Recipients</th>
<th>Current Period Units of Service Provided</th>
<th>Current Period $ Amount</th>
<th>Contract to Date Units of Service Provided</th>
<th>Contract to Date $ Amount</th>
<th>Budget Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prior Period Balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Investment/interest income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. SUBTOTAL (Lines 2 and 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. TOTAL (Lines 1 and 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Approved distributions for Reinvestment Services (identify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ending Balance (Line 5 minus Line 6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 1/03.

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements – Primary Contractor
COUNTY ANNUAL REPORT ON HEALTHCHOICES REINVESTMENT PLANS

_______________________________ COUNTY

<table>
<thead>
<tr>
<th>Name of Service:</th>
<th>________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Plan-Start-up</td>
<td>_____ Supplemental</td>
</tr>
<tr>
<td>Bricks and Mortar</td>
<td>______</td>
</tr>
</tbody>
</table>

| Priority | _____ of _____ for Reinvestment Funds from Contract Year | ______ |

<table>
<thead>
<tr>
<th>Description of Program Service:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Progress in Implementing the Program or Service Including Expenditure of Funds:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Impact on Target Population:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Describe how the Program or Service is meeting the goals of HealthChoices (access, quality of life, improved health outcomes, cost effectiveness, etc.)</th>
</tr>
</thead>
</table>

Note: An updated budget (Attachment 4) must be submitted with this report.

Prepared by: ____________________________ Date: _______________
## HealthChoices Data Support Files For Behavioral Health Managed Care Organizations

### Capitation Payment/Reimbursement Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>820 Capitation</strong></td>
<td>PMRRCSS.MM.zip (P=constant; MM=Plan Code; R=Capitation; CC=Financial Cycle Number; SS=Sequence Number)</td>
<td>File of actual recipients paid for.</td>
<td>Monthly; Sent by the 5th of the month</td>
<td>PROMISe™</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td><strong>MCO Payment Summary File</strong></td>
<td>MPSMYJJJ.MM.zip (MPSM=Constant; YJJJ=Last Digit Year Julian Year; MM=Plan Code)</td>
<td>Summary file of capitation payments by county group rate cell and date of service up to 36 months.</td>
<td>Monthly; Sent by the end of the 2nd week of the month</td>
<td>PROMISe™</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>

### Eligibility/CIS Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARM568 File</strong></td>
<td>xxARM568.ddd (xx=MCO Code; ARM568=Constant; ddd=Julian Date)</td>
<td>Report file of CIS eligibility statistics by county/district.</td>
<td>Monthly; Sent on the Monday following the first full weekend of the month</td>
<td>DPW</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td><strong>Daily Eligibility File</strong> (834 PROMISe™)</td>
<td>FDXXJJJS.MM.zip (F=Constant; D=Daily; XX=Plan Code; JJJ=Julian Day; s=Sequence Number)</td>
<td>File of any change affecting address, category of assistance, county and district indicators, and plan coverage that day for a managed care recipient.</td>
<td>Daily; Sent every state work day</td>
<td>EDS Translator</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td><strong>Monthly Eligibility File</strong> (834 PROMISe™)</td>
<td>FMXXJJJS.MM.zip (F=Constant; M=Monthly; XX=Plan Code; JJJ=Julian Day; s=Sequence Number; X12=Constant)</td>
<td>File of all MA eligible recipients who are covered by the plan at some point in the next month only. One record per recipient (most recent).</td>
<td>Monthly; Sent on the last Saturday of the month</td>
<td>EDS Translator</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td><strong>TPL File</strong></td>
<td>xxTPL788 (xx=MCO Code; TPL788=Constant)</td>
<td>TPL data for each MCO's members.</td>
<td>Monthly; Sent by the 25th of the month</td>
<td>DPW</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>
## Provider Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Active and Closed Provider Files</td>
<td>PRV414M.MM.zip, PRV415M.MM.zip (PRV414 or PRV415=Constant; M=Monthly; MM=Plan Code)</td>
<td>File of statewide MA providers.</td>
<td>Monthly; Sent on the 1st of the month</td>
<td>PROMIS™</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td><strong>Quarterly Network Provider File</strong></td>
<td>PRV640Q.MM.zip (PRV640=Constant; Q=Quarterly; MM=Plan Code)</td>
<td>File of MCO provider returned to the MCO.</td>
<td>Quarterly; Sent on the 1st day of the first month in a quarter</td>
<td>PROMIS™</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>Response to the PRV640M Provider File</td>
<td>PRM640M.MM.rpt (PRM640=Constant; M=Monthly; MM=Plan Code; rpt=Return Report)</td>
<td>Report of MCO provider records returned by DPW due to error.</td>
<td>Monthly; Sent within 48 hrs. of receiving the PRV640M.MM.zip</td>
<td>PROMIS™</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>

## Reference Files:

<table>
<thead>
<tr>
<th>Reference Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference Diagnosis Code File</td>
<td>DIAGYJJJ.MM.zip (DIAG=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code)</td>
<td>ICD-9.</td>
<td>Quarterly; Sent on the second Monday of the 1st month in a quarter</td>
<td>PROMIS™</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>Procedure Code Extract</td>
<td>PROCYJJJ.MM.zip (There are 3 files within this file.) They are: mcmod01.dat, mcproc01.dat, mctype01.dat (PROC=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code)</td>
<td>MA Fee Schedule contained in three files (Procedure/Modifier Max Fee, Procedure, and Provider Type, Specialty, Place of Service).</td>
<td>Monthly; Sent on the 1st of the month</td>
<td>PROMIS™</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>

** HIPAA Implementation Guides and Addenda for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the elements within the 834 and 820 files from the PROMISe system. All file layouts are available from OMHSAS free of charge upon request.
HEALTHCHOICES DATA SUPPORT PROVIDED BY THE DEPARTMENT
FOR BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS

ON-LINE INQUIRY ACCESS:

Each Behavioral Health Managed Care Organization (BH-MCO) will be required to connect to the Pennsylvania Open System Network (POSNet) for the purpose of on-line inquiries and file transfers. Specifications and limited technical assistance will be made available through the Department’s Business Partner HelpDesk. No information made available to the BH-MCO is to be used for any purpose other than supporting their program under HealthChoices.

OMHSAS will provide hands-on training on the use and interpretation of inquiry information found on the system.

- **Client Information System (CIS)**
  The Department will make available to each BH-MCO access to the Department’s CIS database. This database provides eligibility history and demographic information to support the BH-MCO in meeting their obligations.

- **Provider Database System**
  Each BH-MCO has access to provider base information, including provider number, location, enrollment status, provider type, and specialty.

- **Reference Transactions System**
  This system allows BH-MCO inquiry into drug, procedure code and diagnosis code information.

ELIGIBILITY VERIFICATION:

The Department provides the BH-MCO with an additional option for verifying Medical Assistance and HealthChoices eligibility, other than CIS inquiry.

- **Eligibility Verification System (EVS)**
  Each BH-MCO will be provided access to the Department’s EVS. Telephone, Personal Computer software and Point of Sale device methods can be used to access this system. EVS can be used to verify Medical Assistance eligibility, PH-MCO and BH-MCO coverage, primary care practitioner and TPL information.

OMHSAS will provide hands-on training on the use and interpretation of EVS inquiry information.

DATA SUPPORT FILE TRANSMISSIONS:

The Department provides the BH-MCO with several data files for use in managing their program. These files are critical to the effective management of the program. Additional files, other than those listed as attached, may be made available upon request. The Department will transfer files online, as opposed to sending data via tape or other medium. The file formats are subject to change by the Department and by HIPAA mandates.
HealthChoices Behavioral Health
Financial Reporting Requirements (FRR’s)
(RESERVED FOR ALL ZONES)

1.0 Glossary of Terms
2.0 Financial Reporting Requirements Table
3.0 Instructions for the Completion of Reporting Forms
4.0 Reporting Forms
Attachment A: General Assistance Federal Funding Data File Layout
Attachment B: General Assistance Federal Funding File Data Element Dictionary.
Attachment C: Private Psych Hospital In-State (Freestanding)
Attachment D: Reporting Entities
Attachment E: Claims Processing Requirements Document
Attachment F: Administrative Overhead and Clinical Care/Medical Management Cost Definitions.

“Refer to the current FRR issued by the Department of Public Welfare. Contact Beverly Bordner@bebordner@state.pa.us or call (717) 705-8177 for a copy.”
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

PRIORITY POPULATIONS

MENTAL HEALTH  

Reference: Mental Health Bulletin, OMH-94-04

Serious Mental Illness: Adult Priority Group (available in the Proposers’ Library)

In order to be in the Adult Priority Group, a person: must meet the federal definition of serious mental illness\(^1\); must be age 18+, (or age 22+ if in Special Education); must have a diagnosis of schizophrenia, major affective disorder, psychotic disorder NOS or borderline personality disorder (DSM-IV or its successor documents as designated by the American Psychiatric Association, diagnostic codes 295.xx, 296.xx, 298.9x or 301.83); and must meet at least one of the following criteria: A. (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance).

A. Treatment History

1. Current residence in or discharge from a state mental hospital within the past two years; or

2. Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years; or

3. Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or

4. One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or

5. History of sporadic curse of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services, or

6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g., Area Agency on Aging) within the past two years.

\(^1\)Adults with serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (See Reference for additional detail)
B. Functioning Level

Global Assessment of Functioning Scale (DSM-IV-R, pages 12 and 20) rating of 50 or below.

C. Coexisting Condition or Circumstance

1. Coexisting Diagnosis:
   a. Psychoactive Substance Use Disorder; or
   b. Mental Retardation; or
   c. HIV/AIDS; or
   d. Sensory, Developmental and/or Physical Disability; or

2. Homelessness\(^2\); or

3. Release from Criminal Detention\(^3\).

In addition to the above, any adult who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations - Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.

MENTAL HEALTH Child and Adolescent

Reference: "Child and Adolescent Target Groups 1,2, & 3" in 1994 Community Mental Health Services Block Grant Application (Available in the Proposers' Library)

I. The Child and Adolescent Priority Group 1 includes persons who meet all four criteria below:

A. Age: birth to less than 18 (or age 18 to less than 22 and enrolled in special education service).

B. Currently or at any time in the past year have had a DSM-IV diagnosis (excluding those whose sole diagnosis is mental retardation or psychoactive substance use disorder or a "V" code) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

C. Receive services from mental health and one or more of the following:

   1. Mental Retardation
   2. Children and Youth
   3. Special Education
   4. Drug and Alcohol
   5. Juvenile Justice
   6. Health (the child has a chronic health condition requiring treatment)

\(^2\)Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.

\(^3\)Applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision (ARD).
D. Identified as needing mental health services by a local interagency team, e.g., CASSP Committee, Cordero Workgroup.

In addition to the above, any child or adolescent who met the standards for involuntary treatment within the 12 months preceding the assessment (as defined in Chapter 5100 -Mental Health Procedures) is automatically assigned to this priority group.

II. Second priority\(^4\) is associated with children at-risk of developing a serious emotional disturbance by virtue of:

A. A parent's serious mental illness.
B. Physical or sexual abuse.
C. Drug dependency.
D. Homelessness.
E. Referral to the Student Assistance Programs.

---

**DRUG AND ALCOHOL**  
*Reference: Commonwealth of Pennsylvania Federal Fiscal Year 1996, Substance Abuse Prevention and Treatment Block Grant Application*

The priority population for drug and alcohol treatment services includes:

- Pregnant Females and Women with Children
- Intravenous Drug Users
- Adolescents
- Persons with Severe Medical Conditions, such as Tuberculosis and HIV/AIDS.
- Mentally Ill Substance Abusers

---

\(^4\)See reference for additional detail.
The information we request should utilize naming conventions that contain the name of the information contained in the file, the applicable county, and the date of the submission quarter. For example, Adam County’s file name for the first quarter of Fiscal Year 2006/2007 should be PPAD072006.mdb.

1. PP = Prescribing Practitioner
   AD = County Code *
   072006 = Beginning of the fiscal year quarter (MMYYYY)

* When a Behavioral Health Managed Care Organization (BH-MCO) is preparing the file on behalf of a county or group of counties, the county code should be replaced by the abbreviation for that BH-MCO. For example, the same file as above, submitted by Community Care Behavioral Health Organization (CCBH) should be labeled PPCCBH072006.mdb.

2. Enter the physical county location of the provider in the county code field for each provider.

3. When the prescribing practitioner is individually enrolled to participate in Medical Assistance in Pennsylvania, the provider number will be their own. When the prescribing practitioner is employed by an agency enrolled in Medical Assistance in Pennsylvania, the provider number will be the number of that agency.

4. Provider addresses included in the file should be those sites where the prescribing practitioner sees clients. All sites included here must be licensed in accordance with the criteria for each program license.

5. The professional license number and DEA number included in the file must be numbers assigned to the Prescribing Practitioner.

6. A complete refresh of the Prescribing Practitioner database submission will be due as follows:

<table>
<thead>
<tr>
<th>FY Quarter</th>
<th>Period Covered</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>July 1 - September 30</td>
<td>October 15</td>
</tr>
<tr>
<td>2nd</td>
<td>October 1 - December 31</td>
<td>January 15</td>
</tr>
<tr>
<td>3rd</td>
<td>January 1 - March 31</td>
<td>April 15</td>
</tr>
<tr>
<td>4th</td>
<td>April 1 - June 30</td>
<td>July 15</td>
</tr>
</tbody>
</table>

7. An address for every provider must be included in each quarterly file submission.

8. Submissions should be placed on the e-Government server utilizing your approved IP address.

9. Any questions regarding the BH-MCO quarterly submissions may be addressed by sending an e-mail to HC-EligReference@state.pa.us or via telephone toll-free at 800-433-4459.
MANAGED CARE PRESCRIBING PRACTITIONER FILE LAYOUT

DESCRIPTION:

This file will be submitted to eGovernment by each Behavioral Health Plan participating in HealthChoices for every fiscal year quarter on October 15, January 15, April 15 and July 15. It will be used to identify all prescribing practitioners in each network. The Office of Information Systems will, in turn, make the information available via eGovernment to the Physical Health Managed Care Organizations participating in HealthChoices in a format designated by the Office of Medical Assistance Programs.

FORMAT: Access Database

NAMING CONVENTION: PPCCMMYYYY

PP for prescribing practitioner, CC for the two letter county abbreviation, MM for the first month of the quarter being reported, and YYYY for the calendar year. For example, the name of the Adams County file for Fiscal Year 2006/07, 1st Quarter, will be named PPAD072006.mdb.

When a behavioral health managed care organization (BH-MCO) is submitting on behalf of a group of counties, the BH-MCO's abbreviation can replace the county designation in the naming convention. For example, PPCCBH072006.mdb.

DATA RECORD LAYOUT:

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Data Type</th>
<th>Field Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC (County Code)</td>
<td>Text</td>
<td>2</td>
</tr>
<tr>
<td>PT (Provider Type)</td>
<td>Text</td>
<td>2</td>
</tr>
<tr>
<td>PROMISe Prov (Provider) #</td>
<td>Text</td>
<td>9</td>
</tr>
<tr>
<td>Provider Name</td>
<td>Text</td>
<td>50</td>
</tr>
<tr>
<td>Address - Line 1</td>
<td>Text</td>
<td>30</td>
</tr>
<tr>
<td>Address - Line 2</td>
<td>Text</td>
<td>30</td>
</tr>
<tr>
<td>City</td>
<td>Text</td>
<td>18</td>
</tr>
<tr>
<td>State</td>
<td>Text</td>
<td>2</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Text</td>
<td>5</td>
</tr>
<tr>
<td>Phone #</td>
<td>Text</td>
<td>14</td>
</tr>
<tr>
<td>PP (Prescribing Practitioner) Name</td>
<td>Text</td>
<td>30</td>
</tr>
<tr>
<td>PL (Professional License) #</td>
<td>Text</td>
<td>10</td>
</tr>
<tr>
<td>DEA (Drug Enforcement Agency) #</td>
<td>Text</td>
<td>9</td>
</tr>
</tbody>
</table>
## Prescribing Practitioner Desk Reference Table

<table>
<thead>
<tr>
<th>County</th>
<th>Provider Type</th>
<th>Provider #</th>
<th>Provider Name</th>
<th>Address 1</th>
<th>Address 2</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>41</td>
<td>01234568</td>
<td>BDAP Central</td>
<td>115 Shamrock Hall</td>
<td>c/o Ms. Michtich</td>
<td>Harrisburg</td>
<td>PA</td>
<td>17110-0125</td>
</tr>
<tr>
<td>01</td>
<td>41</td>
<td>01234567</td>
<td>BDAP Central</td>
<td>115 Shamrock Hall</td>
<td>c/o Ms. Michtich</td>
<td>Harrisburg</td>
<td>PA</td>
<td>17110-0125</td>
</tr>
<tr>
<td>50</td>
<td>29</td>
<td>01234569</td>
<td>OMAP SE</td>
<td>Dauphin Government Bldg.</td>
<td>789 Park St., Suite 542</td>
<td>Harrisburg</td>
<td>PA</td>
<td>17109-3400</td>
</tr>
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<th>Professional License #</th>
<th>DEA #</th>
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<tr>
<td>(717) 555-4561</td>
<td>Wanda Balmer</td>
<td>MD-00005L</td>
<td>BN0000000</td>
</tr>
<tr>
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<td>Wanda Balmer</td>
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<tr>
<td>(717) 555-2378</td>
<td>Will Washington</td>
<td>MD-00003L</td>
<td>BW2222222</td>
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<tr>
<td>(717) 555-8694</td>
<td>Lisa Page</td>
<td>MD-00002L</td>
<td>BN3333333</td>
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<tr>
<td>(717) 555-2428</td>
<td>Celeste Suggs</td>
<td>MD-00001L</td>
<td>BD4444444</td>
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<tr>
<td>(717) 555-3541</td>
<td>Darlene Sworen</td>
<td>MD-00004L</td>
<td>BD1111111</td>
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<tr>
<td>(717) 555-7730</td>
<td>Laurie Michtich</td>
<td>MD-00000L</td>
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## PRESCRIBING PRACTITIONERS

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<td>July 1 to September 30</td>
<td>10/15</td>
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<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>October 1 to December 31</td>
<td>1/15</td>
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<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>April 1 to June 30</td>
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ADULT

PSYCHIATRIC INPATIENT SERVICES

Admission (must meet criteria I, II, and III):

A physician has conducted an evaluation and has determined that:

I. The person has a psychiatric diagnosis or provisional psychiatric diagnosis, excluding mental retardation, substance abuse or senility, unless these conditions coexist with another psychiatric diagnosis or provisional psychiatric diagnosis, and

II. The person cannot be appropriately treated at a less intense level of care because of the need for:

   - 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person's response to treatment,
   - availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan,
   - the involvement of a psychiatrist in the development and management of the treatment program, and
   - 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment.

III. The severity of the illness presented by the person meets one or more of the following:

   - The person poses a significant risk of harm to self or others, or to the destruction of property.
   - The person has a medical condition or illness which cannot be managed in a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.
• The person's judgment or functional capacity and capability has decreased to such a degree that self-maintenance, occupational, or social functioning are severely threatened.
• The person requires treatment which may be medically unsafe if administered at a less intense level of care.
• There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in danger to self, others, or property.

**Continued stay (must meet criteria I and II):**

I. The severity of the illness presented by the person meets one or more of the following:

• persistence of symptoms which meet admission criteria; or
• development of new symptoms during the person's stay which meet admission criteria; or
• there is an adverse reaction to medication, procedures, or therapies requiring continued hospitalization; or
• there is a reasonable expectation based on the person's current condition and past history, that withdrawal of inpatient treatment will impede improvement or result in rapid decompensation or the re-occurrence of symptoms or behaviors which cannot be managed in a treatment setting of lesser intensity.

and

II. The person continues to need the intensity of treatment defined under Admission Criterion II; and

• a physical examination is conducted within 24 hours after admission; and
• a psychiatrist conducts a psychiatric examination within 24 hours after admission; and
• the person participates in treatment and discharge planning; and
• treatment planning and subsequent therapeutic orders reflect appropriate, adequate and timely implementation of all treatment approaches in response to the person's changing needs.

**Discharge Indicators (must meet I or II):**

I. The person no longer needs the inpatient level of care because:

• The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
• The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and

• The person does not pose a significant risk of harm to self or others, or destruction of property; and

• There is a viable discharge plan which includes living arrangements and follow-up care

or

II. Inpatient psychiatric treatment is discontinued because:

• A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or

• The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or

• The person is transferred to another facility/unit for continued inpatient care.

PARTIAL HOSPITALIZATION

Admission (must meet criteria I, II, and III):

I. A mental health professional, as defined in Chapter 5210.3 of the Partial Hospitalization regulations, has conducted an evaluation and has determined that the person meets one of the following:

• The person has an established history of a psychiatric disorder, excluding mental retardation, substance abuse or senility, unless these conditions co-exist with other psychiatric symptomatology, and is presenting symptoms which require this level of care; or

• The person does not have an established psychiatric history, but a psychiatrist, or physician, or a licensed clinical psychologist has been consulted and has confirmed the presence of a psychiatric disorder that requires this level of care; or

• The person has had an evaluation by a psychiatrist, a physician, or a licensed clinical psychologist at another mental health treatment facility, (e.g., inpatient, outpatient or crisis intervention) and is being directly referred to this level of care; or

• The person needs a diagnostic evaluation that cannot be performed at a lesser level of care.

and

II. The partial hospital level of care is appropriate because:
• The person has the capacity to participate in the partial hospitalization level of care; and
• The person has a community based network of support that enables him/her to participate in the partial hospitalization level of care; and
• The person exhibits sufficient control over his/her behavior such that he/she is judged not to be an imminent danger to self, others or property.

and

III. The severity of the symptoms presented by the person meets one or more of the following:

• The person's judgment or functional capacity and capability is compromised to such a degree that self-maintenance, occupational, educational or social functioning are significantly impaired, and the severity of the presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
• The person requires treatment which may be unsafe if administered at a less intense level of care; or
• Sufficient clinical gains have not been made within a less intensive level of care, and the severity of presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
• Co-existing, non-psychiatric medical conditions preclude treatment at a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

Continued Stay Criteria (must meet criteria I and II)

I. One or more of the symptoms or conditions which necessitated admission persist, or new symptoms develop which meet admission criteria, and the person meets one or more of the following:

• The person has not completed the goals and objectives of the Individualized Treatment Plan that are necessary to warrant transition to a less intensive level of care; or
• The person demonstrates a current or historical inability to sustain/maintain gains without a comprehensive program of treatment services provided by the partial hospital program; or
• Attempts to reduce the intensity and structure of the therapeutic program have resulted in, or are likely to result in, exacerbation of the psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
• Attempts to increase the person's level of functioning or role performance in the areas
of interpersonal, occupational or self-management functioning have resulted in exacerbation of psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or

- An adverse reaction to medication, procedures or therapies requires frequent monitoring which cannot be managed at a less intensive level of care.

and

II. The partial hospital program provides the following service elements:

- The person is receiving active treatment within the framework of a multi-disciplinary individualized treatment plan approach; and
- There is the involvement of a psychiatrist in the development and management of the treatment program and discharge plan; and
- The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to respond to changes in the person's clinical presentation or lack or progress; and
- The person is an active participant in treatment and discharge planning; and
- Where clinically appropriate, and with the person's informed consent, timely attempts are made by the treatment team, and documented in the treatment plan, to involve the family and other components of the person's community support network in treatment planning and discharge planning.

**Discharge Indicators (must meet I or II):**

I. The person no longer needs the partial hospital level of care because:

- The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
- The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
- There is a viable discharge plan with which service and care providers identified for after-care treatment, if needed, and support have concurred.

or

II. The partial hospital level of care is discontinued because:

- The diagnostic evaluation has been completed when this constitutes the reason for admission; or
- The person withdraws from treatment against advice and does not meet criteria for
- involuntary commitment; or
- The person is transferred to another facility/unit for continued care.
**Admission (must meet criteria I and II):**

I. A mental health professional determines that the outpatient level of care is appropriate and there is the potential for the person to benefit from outpatient care. The person must meet at least one of the following condition elements:

- The person has a psychiatric illness exhibited by reduced levels of functioning and/or subjective distress in response to an acute precipitating event; or
- The person is exhibiting signs or symptoms of a psychiatric illness, associated with reduced levels of functioning and/or subjective distress; or
- The person has a history of psychiatric illness and presents in remission or with a residual state of a psychiatric illness, and without treatment there is significant potential for serious regression,

and

II. A comprehensive diagnostic evaluation, including an assessment of the psychiatric, medical, psychological, social, vocational and educational factors important to the person, is conducted.

**Continued Stay (must meet criteria I, II and III):**

I. The person has a current psychiatric diagnosis or provisional psychiatric diagnosis.

and

II. The treatment team determines that:

- The person continues to exhibit one or more signs or symptoms that necessitated admission and can be expected to benefit from the outpatient level of care; or
- The person has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care; or
- There is a reasonable expectation based on the person's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs or symptoms.

III. The services provided to the person meet the following criteria:

- The person is an active participant in treatment and discharge planning; and
- A psychiatrist reviews and approves the treatment plan; and
• The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to address changes in the person's clinical presentation and response to treatment; and
• The person is receiving treatment within the framework of a multidisciplinary individualized treatment plan approach.

**Discharge Indicators**

• The person no longer meets continued stay criteria; or
• The person withdraws from treatment against advice and does not meet criteria for involuntary treatment.
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

ADULT

TARGETED CASE MANAGEMENT SERVICES

Admission (must meet criteria I and II):

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management or a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; July, 30, 1993 and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The person meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management.

An adult who needs to receive targeted case management services but who does not meet the requirements identified above may be eligible for targeted case management services upon review and recommendation by the County Administrator.

and

II. The person is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.
**Continued Stay and/or Change of Level of Need**
(must meet criteria I and II):

The consumer must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual’s situation that warrants a change in level of TCM services.

I. The consumer continues to meet at least 2 out of the 3 of part A Admission Criteria.

and

II. The person is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

**Discharge Indicators**

I. Targeted Case Management may be terminated when one of the following criteria is met:

   A. The consumer receiving the service determines that Targeted Case Management is no longer needed or wanted and the consumer no longer meets the continued stay criteria; or

   B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the adult receiving the service and the consumer no longer meets the continued stay criteria; or

   C. The consumer receiving the service determines that Targeted Case Management is no longer wanted, however, the consumer does meet continued stay criteria; or

   D. The consumer has moved outside of the current geographical service area (e.g., county, state, country); or
E. The consumer is undergoing long-term incarceration and/or long-term hospitalization or long-term skilled-nursing care without a discharge or anticipated discharge date.

TCM ENVIRONMENTAL MATRIX — ADULTS

INSTRUCTIONS

The Environmental Matrix - Adults is a scale that evaluates the functional level of consumers on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator. Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

The scale has a range from 0 to 5 with the following values for each activity:

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<tr>
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<td>No assistance Needed</td>
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<td>Needs Moderate assistance in this area</td>
<td>Needs Significant assistance in this area</td>
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. Alcohol and other drug use.
. Socialization/support
. Activities of daily living
. Medical treatment
. Legal situation
. Transportation issues
. Criminal justice system involvement

Each area is defined at the “1”, “3”, and “5” levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of consumer need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, of the consumer during the last ninety (90) days, rate the consumer’s functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your professional judgement*, and other information (e.g., cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the consumer’s level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in Chapter 5221, Intensive Case Management regulations and Bulletin OMH-93-09, Resource Coordination: Implementation.) If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgement in “Other Factors/Issues Affecting Score” section of the scoring sheet. Note: The level of service indicated by the assessment represents the individual’s needs at the time of assessment.
Service intensity could change as an individual’s needs and/or desires for service change.

Please note:
- Although a person may not meet the eligibility criteria and/or the Environmental Matrix formulary, inclusive of professional judgement and other information that impacts on the individual’s need for the service, he/she may be authorized for Targeted Case Management Services upon the recommendation of the County Administrator and/or designee.

### ENVIRONMENTAL MATRIX

#### TCM SERVICE SCORING GRID

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<th>MATRIX LEVEL</th>
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<th>INTENSITY OF CARE</th>
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<tr>
<td>4.0 – 5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended).</td>
</tr>
<tr>
<td>1.5 – 3.9</td>
<td>RC</td>
<td>At least 1 face to face contact every two months</td>
</tr>
<tr>
<td>0.0 – 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
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</table>

*professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.*
ASSESSMENT & SERVICE PLANNING

The consumer is able to provide meaningful and accurate information regarding own mental health status and needs. The consumer, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e., language, perceived/actual institutional racism/discrimination, etc.)

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able to provide meaningful/relevant/accurate information regarding own mental health status. Consumer is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Consumer is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities.

3= Consumer needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Consumer needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5= Consumer needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Consumer is unable to express personal goals nor objectives without assistance. Consumer needs and/or requests significant assistance from others to design/formulate service plan and activities.
USE OF COMMUNITY RESOURCES

The consumer is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The consumer may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able, when encouraged, to identify and articulate daily living needs. Consumer is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Consumer’s needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and consumer is able to utilize these with minimal assistance.

3= Consumer needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the consumer may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.
5= Consumer is unable to identify nor understand daily living needs. Consumer is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Consumer needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

**INFORMAL SUPPORT NETWORK BUILDING**

The consumer identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the consumer may gain informal support. The TCM should recognize that service system barriers may impede the consumer from interacting with family, friends, significant others and community groups. The consumer may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom consumer interacts and from whom consumer may gain informal support. Consumer is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Consumer needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom consumer may gain informal support. Consumer needs and/or
requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Consumer is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Consumer has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Consumer needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

**LINKING AND ACCESSING SERVICES**

The consumer is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the consumer. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Consumer is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Consumer needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3= Consumer needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Consumer may
require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

5= Consumer is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Consumer’s identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Consumer needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

**MONITORING OF SERVICE DELIVERY**

The consumer gauges and communicates her/his satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The consumer suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the consumer in suggesting changes in the treatment plan/service plan or actual provider.

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<td>Needs minimal assistance in this area</td>
<td>Needs moderate assistance in this area</td>
<td>Needs significant assistance in this area</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Consumer is able and
willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the consumer is satisfied with the services received.

3= Consumer needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Consumer needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5= Consumer is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Consumer needs and/or requests significant assistance to communicate effectively and realistically about her/his progress and satisfaction with the service provider and/or the services delivered.

### PROBLEM RESOLUTION

The consumer is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevent her/him from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The consumer is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the consumer with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCO in order to overcome barriers and to assist the consumer in obtaining needed services.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Needs minimal assistance in this area</td>
<td>Needs moderate assistance in this area</td>
<td>Needs significant assistance in this area</td>
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</tr>
</tbody>
</table>
0= Consumer does not need/or request assistance in this area.

1= Consumer needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

3= Consumer is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

5= Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services. Consumer is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.
TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - ADULT

Agency

County

CONSUMER INFORMATION:

Name :

(Last)     (First)     (MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth:          /        /

(MM)/(DD)/(YYYY)

Social Security Number: - - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

FormCompletedby:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to
determine an individual’s need for the various levels of case management services. Please
complete this form utilizing the individual’s behavior during the last ninety days as a
basis for scoring each indicator. Please see the Scoring Sheet for additional information
on determining the Environmental Matrix Score and its meaning for level of care
assignments.
ENVIRONMENTAL MATRIX ADULT SCORING SHEET

CONSUMER NAME: ____________________________________________________________

ID#(SOCIAL SECURITY/CIS/BSU): ____________________________________________

SCORES:

1. Assessment and Service Planning _____________________
2. Use of Community Resources _____________________
3. Informal Support Network Building _____________________
4. Linking and Assessing Services _____________________
5. Monitoring of Service Delivery _____________________
6. Problem Resolution _____________________

SUBTOTAL _____________________

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ 6= _____________________

OTHER FACTORS/ISSUES AFFECTING SCORE:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID

<table>
<thead>
<tr>
<th>MATRIX LEVEL</th>
<th>NEED LEVEL</th>
<th>INTENSITY OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 –5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended).</td>
</tr>
<tr>
<td>MATRIX LEVEL</td>
<td>NEED LEVEL</td>
<td>INTENSITY OF CARE</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>1.5 – 3.9</td>
<td>RC</td>
<td>At least 1 face to face contact every two months</td>
</tr>
<tr>
<td>0.0 - 1.4</td>
<td>NO TCM NECED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
</tr>
</tbody>
</table>

*professional judgement:* opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.

**RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

**CONSUMER:** ___________________________ **DATE:** ________________

**PERSON COMPLETING THE FORM:** ___________________________ **DATE:** ________________

**APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

**REVIEWER** ___________________________ **DATE:** ________________
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

PSYCHIATRIC INPATIENT HOSPITALIZATION
RESIDENTIAL TREATMENT
PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS
PSYCHIATRIC OUTPATIENT TREATMENT

Purpose

The purpose of this document is to provide decision-making criteria for the admission of children and adolescents to four (4) treatment environments under regulation. This document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse Services (OMHSAS) program, and Office of Medical Assistance Programs (OMAP) payment regulations, for deciding when to treat, continue or discontinue treatment, and refer elsewhere for other services. These criteria will serve the basis for decision-making for Managed Care Organizations (MCOs), county Mental Health/Mental Retardation (MH/MR) offices, and prescribers of children's mental health services in general, as well as for providers delivering their respective services to children qualifying for Medical Assistance (MA) coverage. This document provides a common set of criteria for reference by all the decision-makers in a child's care. These four (4) sets of criteria are intended to further consistency between the child's treatment needs and the broader philosophy of individualized service delivery in the most appropriate and least restrictive setting as guided, respectively, by the principles of the Child and Adolescent Service System Program (CASSP) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) produced Title 55 PA Code Chapters 5100, 5300, 4210, 5200, 5310, and 5210 to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP produced Title 55 PA Code, Chapters 1151 and 1153 to regulate M.A.
payment for these services. Additional clarity for psychiatric residential treatment is provided in OMHSAS's proposed Chapter 5215 regulations. However, as more mental health services are developed for delivery in the home and community, in conjunction with a growing emphasis on providing services in the least restrictive environments necessary, greater clarity is required for mental health providers, case managers, interagency teams, and third party payers, including Managed Care Organizations and their sub-contractors, to make coordinated treatment determinations concerning appropriateness of admissions, continued stay, and discharge planning. It is for this reason that the criteria provided below have been developed.

Presented in the opening section which precede the criteria, is a summary outline of the major aspects of service delivery, including: CASSP principles, the function of each of the four (4) treatment environments, and the importance of prescribing the least restrictive setting necessary. More detail is provided by the addenda in the document. Following the introduction are the individual "Admission Criteria" for each service. Each set of criteria is divided into three (3) sections, the first for determining "Admission", the second for determining the appropriateness of "Continued Stay," and the third for identifying "Discharge Criteria."

For ease of reading in the following text, "child(ren) and adolescent(s)" shall be commonly referred to as "child(ren)," unless otherwise indicated.

Introduction

The mental health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and fostering increasing independence of individuals (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). These changes are further reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. The OMHSAS summary representation of CASSP, is provided below:

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation for the development of these criteria. These principles are represented in the following six summary statements:
(1) **Child-centered** - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) **Family-focused** - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) **Community-based** - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) **Multi-system** - Services should be planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) **Culturally competent** - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) **Least restrictive/least intrusive** - Services should take place in settings that
are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the four services for which "Admission Criteria" are provided below, can be understood as components within a wider network of service options.

**Severity of Symptoms**

The child's expression of impairment in any of the following should be considered in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must also be considered when determining an appropriate treatment design, and the concomitant discharge planning.

**Intensity of Treatment**

The intensity and range of treatment varies for each of the four services. Psychiatric Inpatient and Residential Treatment are out of home services which provide highly intensive treatment for the purpose of returning children home, or to a homelike setting. Partial Hospitalization and Psychiatric Outpatient provide services of varying intensity depending on the child's need for therapeutic support to remain home. The therapeutic function and emphasis of each of the four services to return a child home, or to prevent out-of-home placements, depends strongly on the interaction between the therapist, the parents/guardians, and the child, for the effectiveness of the treatment plan developed.

Psychiatric Inpatient hospitalization provides the most restrictive level of care. The setting is locked and highly focused toward the delivery of intensive, short term treatment. It serves as an appropriate placement for children expressing the sudden onset of acute symptoms, and/or requiring treatment which cannot be managed outside of a 24 hour, secure setting.

Residential Treatment facilities provide a stable, open, community living setting for the delivery of comprehensive mental health treatment with 24 hour monitoring and a strong supportive environment from which the child is able to
reenter the community. This is a longer term treatment option for children who require the comprehensive treatment and professional support of this setting to prevent a need for inpatient hospitalization.

Partial hospitalization lies between the most restrictive and community-based levels of care. A partial hospitalization treatment program offers a wide range of treatment in a setting segregated from the child's natural setting for part of the day. Effective treatment and stabilization of the child must be possible within the partial hospital program hours prescribed in the treatment plan. Partial hospitalization provides an opportunity to observe a child's behavior and the effects of treatment, for the purpose of developing and confirming a proper course of treatment designed for the effective reintegration of the child into the community.

Outpatient treatment is for children and their families who are seeking help and believe there is a need for mental health services. Services and treatment approaches include, diagnostic testing, crisis intervention services, behavior therapy, individual, group and family psychotherapy, medication, and similar services. The child should be able to maintain sufficient stability in his/her existing support network, to be treated effectively within the hours of outpatient treatment prescribed in the treatment plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and work to prevent the necessity of a more restrictive or intrusive service.

**Least Restriction**

The four services addressed in this bulletin are presented in descending order of restrictiveness and in increasing order of community integration. The need for greater or lesser restrictiveness must be adjusted to the individual's need for active treatment as reflected in the treatment plan. Increased restrictiveness of setting improves the convenience and opportunity for immediate intervention in the delivery of treatment. However, less restrictive environments should be considered to prevent the removal of children from their families, peers, and normalized settings in the community. Each service provides treatment with the object of helping a child with acute behavioral problems or serious emotional disturbance to increase his or her functional capacity, in order to increase his/her ability to reintegrate into the community. Therefore, the goals of treatment may be summarized by the following:

- amelioration of symptoms such that less restrictive and/or less intrusive services can be planned and introduced;
- stabilization of medical regimen for children requiring psychotropic medication so they may remain in the least restrictive setting possible;
- prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance;
- coordination of the treatment and discharge plan on an ongoing basis with the family and the appropriate agencies to provide the necessary community based supports, including wraparound services; and
- increase in the age-appropriate interactiveness in a variety of settings [see Community Integration Attachment in Appendix C].
Psychiatric Inpatient Hospitalization

Admission of a child for psychiatric inpatient treatment is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. When a certified psychiatrist is not available, a diagnosis may be provided by a Board eligible psychiatrist or a licensed physician contingent on confirmation by a Board Certified psychiatrist within forty-eight (48) hours of admission, or as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician contingent on confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:

---

1 Diagnosis by a resident physician with training license must receive confirmation within 24 hours.
- severe mental illness or emotional disorder, and/or
- behavioral disorder indicating a risk for safety to self/others;
AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, and/or careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, and the direct reasons for its rejection, have been documented;
AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admission.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following,
   1. child HARMING HIM/HERSELF
   2. child HARMING OTHERS
   3. DESTRUCTION TO PROPERTY which is:
      a. life-threatening, OR
      b. in combination with "B", "C", or "D" below; OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;
   OR

C. There are endangering complications in either of the following:
   1. complications of the child's psychiatric illness or treatment would seriously threaten the child's health safety due to a lack of capacity for self-care; OR
   2. due to a coexisting medical condition where the child has a medical condition or illness which, as a result of a psychiatric condition, cannot be managed in a less intensive level of care without significant risk of medical crisis or instability;
   OR
D. The severity of the child's symptoms are such that continuation in a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified in the above three categories of "II."

Requirements for Continued Stay
(Must meet I and II. Complete documentation for each is required, and additional documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
   A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the treating psychiatrist;
      AND
   B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS
   A. Severity of illness indicators and updated treatment plan support the likelihood that: substantial benefit is expected as a result of continued active intervention in a psychiatric inpatient setting, without which there is great risk of a recurrence of symptoms; OR severity is such that treatment cannot be safely delivered at a lesser level of care, necessitating hospitalization;
      AND
   B. Although child is making progress toward goals in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review must recommend continued stay;
      OR
   C. The symptoms or behaviors that required admission, continue with sufficient acuity that a less intensive level of care would be insufficient to stabilize the child's condition;
      OR
   D. Appearance of new symptoms meeting admission criteria.
III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.
Residential Treatment Facilities

Admission of a child to a JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child psychiatrist a diagnosis may be appropriately provided by a Board Certified psychiatrist. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained. Admission to a Non-JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis as described above for JCAHO accredited facilities, or by a licensed psychologist specializing in treatment for children and adolescents.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA
(Must meet I and II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
   A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in Chapter 5200.3 of the Pennsylvania Code) for JCAHO accredited facilities, or by a psychiatrist or a licensed psychologist for Non JCAHO accredited facilities;
      AND

   B. Residential Treatment service is prescribed by the diagnosing psychiatrist or psychologist, as appropriate to the accreditation of the facility, indicating that this is the most appropriate, least restrictive service to meet the mental health needs of the child;
      AND
C. Documentation in the current psychiatric/psychological evaluation\textsuperscript{2} that the treatment, 24-hour supervision, and observation, provided in the Residential Treatment setting, are necessary as a result of:
   - severe mental illness or emotional disorder, \textit{and/or}
   - behavioral disorder indicating a risk for safety to self/others;
   \textit{AND}

D. Reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, \textit{and/or} careful consideration of treatment within a less restrictive environment than that of a Residential Treatment Facility, \textit{and} the direct reasons for its rejection, have been documented;
   \textit{AND}

E. Placement in a Residential Treatment Facility must be recommended as the least restrictive and most clinically appropriate service for the child, by an interagency service planning team as currently required by the OMHSAS and OMAP. Following PA School Code, Sections 1306-1309 and 2561, when a child is removed from the school setting for the purpose of receiving mental health treatment, it is expected that the appropriate school system will be involved in the child's educational planning and the interagency team. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team;
   \textit{AND}

F. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission.

II. SEVERITY OF SYMPTOMS
   The child's problematic behavior \textit{and/or} severe functional impairment discussed in the presenting history \textit{and} psychiatric/psychological examination must include at least one (1) of the following:

\textsuperscript{2} A current psychiatric/psychological evaluation is one which has been conducted within sixty (60) days prior to admission to the program. A psychiatric/psychological evaluation for a child placed on a waiting list during which time the thirty (30) day maximum has passed, shall continue to be "current" for an additional thirty (30) days. (updated 9/10/09)
A. Suicidal/homicidal ideation
B. Impulsivity and/or aggression
C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
D. Psychomotor retardation or excitation.
E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
F. Psychosocial functional impairment
G. Thought Impairment
H. Cognitive Impairment

III. OBSERVATION
The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist/psychologist must clarify the criteria for admission under II AND/OR recommend development of a discharge plan. Should it be found that the child does not fit the criteria for admission, an appropriate discharge plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, or
   - they are denied by the child in outpatient or partial hospitalization treatment,
   such that the residential treatment milieu provides an ideal opportunity to observe and treat the child;

   OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION  (see also, Appendix A)
A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the appropriate treating psychiatrist or psychologist;

    AND

B. Less restrictive treatment environments have been considered in consultation with the Interagency Service Planning Team;

    AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Residential Treatment setting, without which there is great risk of a recurrence of symptoms;

    AND

D. Any other clinical reasons supporting the rejection of other alternative services in favor of continuing Residential Treatment;

    AND

E. Residential Treatment service is prescribed by the diagnosing psychiatrist/psychologist following a current face-to-face psychiatric evaluation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan.

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: substantial benefit is expected as a result of continued active intervention in a psychiatric residential treatment setting, without which there is great risk of a recurrence of symptoms; OR severity is such that treatment cannot be safely delivered at a lesser level of care;

    AND

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

    AND
C. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review, in conjunction with an interagency team, must recommend continued stay; OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition; OR

E. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA
   A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

   B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.
Partial Hospitalization Programs

Admission of a child to a Partial Hospitalization Program is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA
(Must meet I and II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
   A. Diagnosis on DSM IV Axis I or Axis II as part of a complete multiaxial diagnostic examination (MR or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in Chapter 5200.3 of the Pennsylvania Code);
      AND

   B. Behaviors which indicate a risk for safety to self/others, and/or decreased functioning for the child's developmental level, such that:
      1. this behavioral disturbance requires regular observation and treatment, but does not require 24-hour supervision, and
      2. reasonable treatment within a less restrictive setting has been attempted by a mental health professional, or treatment in a less restrictive setting has been considered and documented, but is rejected directly in favor of partial hospital treatment;
      AND

   C. Partial hospitalization must be recommended as the most clinically appropriate and least restrictive service available for the child, by the treatment team [as described in PA 55 §5100.2.] to also include: child, parent/guardian and/or caretaker, and case manager;
      AND
D. Removal of a child from his/her regular classroom for all or part of the school day necessitates the incorporation of an interagency planning team (in accordance with Chapter 5210.24,(b), except when partial provides acute hospital diversion. [The interagency planning team must include the appropriate representative from the child's local school in compliance with PA School Code, Sections 1306-1309 and 2561, and establish that the child's mental health needs cannot be otherwise met with appropriate supports in a school setting]

AND

E. A treatment plan [See PA 55 §5210.35], to include a complete strengths-based assessment of the child, including identifying the strengths of child's family, community, and cultural resources, can be completed prior to admission or within five (5) days of service in the partial hospitalization program;

AND

F. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents, and/or reasons explaining their non-involvement, must be fully documented and presented to the interagency team.

II. SEVERITY OF SYMPTOMS
The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination must include at least one (1) of the criterion in A through F with a severity level as indicated in "B" above.

A. Suicidal/homicidal ideation
B. Impulsivity and/or aggression
C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
F. Psychosocial functional impairment
G. Thought Impairment
H. Cognitive Impairment
III. OBSERVATION
The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist must clarify the criteria for admission under II AND/OR recommend development of a transition plan. Should it be found that the child does not fit the criteria for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
- they are not observed on a psychiatric inpatient unit, or
- they are denied by the child in outpatient treatment, such that the day treatment milieu and return to home environment daily, provides an ideal opportunity to observe and treat the child; OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team in planning, coordinating and providing this treatment, and the interagency team currently recommends this level of treatment.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)
   A. The initial evaluation and diagnosis is updated and revised as a result of a current face-to-face diagnostic examination by the treating psychologist or psychiatrist; AND

   B. Less restrictive treatment modalities have been considered; AND

   C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Partial Hospitalization Program, without which there is great risk of a recurrence of symptoms; AND
D. Any other reasons supporting the rejection of other alternative services in favor of continuing Partial Hospitalization;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a partial hospitalization program, without which there is *great risk of a recurrence of symptoms*; *OR* severity is such that treatment cannot be safely delivered at a lesser level of care;

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Child is making *progress toward treatment goals* in the expected treatment process as evidenced by reductions in the problematic signs, symptoms, and/or behaviors the child presented upon admission; and the treatment team or interagency team review recommends continued stay, documenting the need for further improvement and the corresponding modifications in both treatment plan and the discharge goals;

OR

D. The *symptoms or behaviors* that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. The appearance of *new problems, symptoms, or behaviors* meet the admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF
SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.
Psychiatric Outpatient Treatment (Clinics)

Admission of a child for Psychiatric Outpatient Treatment (clinic) is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided by a developmental pediatrician or otherwise as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
   A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.22(d) and § 5200.31);
      AND
   B. Behaviors indicate minimal risk for safety to self/others and child must not require inpatient treatment or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS
   A. Service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the treatment team director [described in PA 55 §5100.2], as informed by the treatment team [described in PA 55 §5210.34]. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when one is assigned) and the child must be involved in the planning process. Where a parent or the child are not or cannot be involved, the attempts
to involve either or both and the reasons for non-involvement must be documented. The treatment team should otherwise recommend the most appropriate alternatives should treatment at an outpatient clinic not be recommended;

AND

B. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission; OR

C. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level; OR

D. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of outpatient treatment to sustain and reenforce stability; OR

E. Requires prescription and monitoring of medications to mitigate the effects of the child's symptoms.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
   A. Revised and updated diagnosis by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.31);
      AND

   B. There is significant family (including the child) cooperation and involvement in the treatment process, except where the involvement of family members other than the child would be clinically counter-productive or legally prohibited.
II. **SEVERITY OF SYMPTOMS**

A. Child is making *progress toward goals*, and the treatment team review recommends continued stay; 

OR

B. The *presenting conditions, symptoms or behaviors continue* such that natural community supports alone are insufficient to stabilize the child's condition; 

OR

C. The appearance of *new problems, symptoms*, or behaviors meet the admission criteria.

III. **DISCHARGE CRITERIA**

A child not meeting criteria as established in Section II, **SEVERITY OF SYMPTOMS**, of the **CONTINUED STAY CRITERIA**, must be discharged.
FUNCTION OF THE FOUR SERVICES

Inpatient Hospitalization:
• Inpatient hospitalization provides a locked setting for the delivery of acute care.

• Inpatient hospitalization combines security and restrictiveness with intensive treatment, for the purpose of ameliorating symptoms and reducing the need for such intensity of service by establishing within the child the self-control and/or capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.

• Inpatient hospitalization provides service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a secure setting.


• Treatment components include: major diagnostic assessments, medical and psychiatric treatment, and psychosocial rehabilitation (to include educational components, as appropriate to the child's development).

Residential Treatment Facilities:
• Residential Treatment Facilities provide a safe environment within a restrictive setting for the delivery of psychiatric treatment and care. However, it is an unlocked, and otherwise, less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care and for the provision of transitional care from an acute inpatient setting.

• Residential Treatment Facilities offer the comprehensive and intense services needed for the purpose of ameliorating symptoms, by establishing within the child the self-control, the capacity for constructive expression, and the adaptive interpersonal skills necessary to continue in a more natural and less restrictive setting.

• Residential Treatment Facilities provide service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting.

• Treatment components include: major diagnostic assessments, psychiatric and other medical treatment, and psychosocial rehabilitation. Psychosocial rehabilitation is an
important vehicle through which psychiatric residential treatment facilities provide culturally competent service. These services provide the child with community linkages and the real world competency necessary for his/her successful return to the community.

- Residential Treatment Facilities must collaborate with the school district of residency, and, if different, the school district where the child in treatment is enrolled, to ensure the child receives educational instruction in the least restrictive setting appropriate to meet their needs while accommodating their behavioral and psychiatric difficulties (see Commonwealth of Pennsylvania, OMH-95-07; BEC 19-93; OCYF.

- Parents/guardians are actively involved in the treatment planning process and provided the opportunity to address the treatment of the child in the broader context of the family system. They may receive other additional supports necessary to develop the therapeutic environment the child needs to return home or to other community settings, including training and family therapy. Also, parents/guardians are to be informed of the appropriate parent support and advocacy groups available [see addendum], or any other involvement consistent with the applicable regulations.

Partial Hospitalization Programs:

- Partial hospitalization provides a less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care, by providing transitional and diversionary care from an acute inpatient setting.

- Partial hospitalization provides a short-term, intensive outpatient treatment as a transition to Outpatient Clinic services. Its purpose is to reduce the child's need for restrictive therapeutic settings for treatment, and help the child develop the necessary self-control and/or capacity for constructive expression, including more adaptive interpersonal skills, to make the transition to interacting more fully in family and community environments.

- Partial hospitalization provides service for children with serious mental and/or psychosocial disorders who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a single setting (see "Settings" below).

- Partial hospitalization provides day, after school, weekend, and evening service for children with mental and/or psychosocial disorders, so that:
  - the child receives the additional support necessary to interact effectively and cooperatively with family members, thereby helping to insure the family bond;
  - parents/guardians can receive family therapy/treatment consistent with the treatment of their child.
Partial hospitalization uses group approaches to the treatment of children with serious mental and/or psychosocial disorders.

Treatment components include: major diagnostic assessments, medical and psychiatric treatment, psychosocial rehabilitation (to include educational and prevocational components, as appropriate to the child's development), individual and group therapies and opportunities for family therapy. Recognizing the responsibility of the school districts to provide an educational program for all children, full day or school day partial hospitalization programs must collaborate with the school district of residency and the school district where the child in treatment is enrolled, to incorporate an educational program within the therapeutic milieu.

**Program Range** - Partial hospitalization programs vary in the intensity and purpose of the services offered. The range of programs includes, on the one end, those serving a more acute population as a step-down from inpatient treatment, or as a preventive for a more restrictive treatment setting. On the other end are programs serving those with more long standing impairments, where clinical judgement suggests that partial hospitalization is therapeutically necessary to return the child or maintain the child in a stable condition while providing effective treatment.

**Settings** - Child partial hospitalization programs serve a range of age groups from pre-school to late teens, and they also occur in a variety of settings. Typical settings may be characterized individually or in combination by place, such as, school settings, clinics, and free-standing units; by specified time of service, such as, morning, afternoon, all day, after-school, and evening, and some have 24 hour emergency phone service; and by established age categories, such as, pre-school, children, and adolescents. In those provided in public and private school settings serving the general population, the school system and the mental health system collaborate closely in meeting the educational and mental health needs of the child. Many facilities described as "free-standing" are designed specifically for those children who require a secure setting for mental health treatment, and the coordination of education and treatment in the same setting. In other settings, such as a mental health agency, the educational component must be designed and developed to meet the child's needs in collaboration with the mental health agency.

**Outpatient Treatment:**
- Provision of services which are less restrictive, more flexible yet effective supports for patients discharged from in-patient or partial hospitalization. In this way outpatient services provide for the delivery of transitional care from a more restrictive setting.
• Prevent the need for more intense services, or accompany more enhanced or community based services, to help the child develop the necessary self-control, and/or capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

• Provision of service for children with mental and/or psychosocial disorders who require the periodic support provided by this treatment, to remain stable and ensure the effectiveness of a treatment plan.

• Provision of after school service for children with mental and/or psychosocial disorders, so that:
  ○ parents/guardians can receive the additional support necessary to maintain a therapeutic environment for the child;
  ○ parents/guardians can receive family therapy consistent with the treatment of their child.

Should service require removing the child during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

• Treatment components include: major diagnostic assessments, medical and psychiatric treatment. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is problematic, the reasons must be clearly documented.

Treatment Range- Outpatient treatment varies in both intensity and purpose. Intensity may be reflected in the number and length of visits as well as the duration and types of service offered. The range of service provides support for a more acute population and for those without long standing impairments, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to or maintain the child in a stable condition. Outpatient treatment may serve as a step-down from inpatient treatment and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the support of short term services to ameliorate the presiding condition or stress.

Outpatient treatment is clearly identified by the setting from which it is offered. In concordance with Title 55 Public Welfare, Chapter 5200 Psychiatric Outpatient Clinics, the domain of this level of treatment for the scope of this document is the clinic, exclusive of partial hospitalization and other day-treatment programs.
Continued Stay Service Documentation

The following list of information should be documented for all four services.

1. Routine assessments and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge criteria formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary supports for the child's successful transition into the community, including mental health and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to a less restrictive setting.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of
the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan and/or plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization must be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.
Community Integration Questionnaire

1. Are the child's **interest areas?** and **strengths?** documented, with a plan to **explore new interests and strength's** for the child?

2. Have the child's **community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been recruitment of family members, or other significant individuals, to participate as designated support persons

4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?

6. Does the **treatment plan** include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events; school sponsored clubs and gatherings; extra-curricular classes (ie. dance, music, martial arts, etc); church or community center picnic, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities [such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

   **OR,** for children who may be more severely impaired:
   - staff oversite of planned parental supervised activities?
   - staff supervised activities for parent/child interaction?
     for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a **plan of reinforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the treatment setting?
8. Do the progress notes detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to measure the outcome of a child's participation in a home/community activity?

10. Do you have a plan to expand the child's home/community/cultural participation?
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CHILDREN AND ADOLESCENTS

Behavioral Health Rehabilitation Services Under EPSDT: Home/Community Services (2nd Edition)

- Serious Emotional Disturbance
- Mental Retardation

INTRODUCTION:

Generally absent in both regulation and the literature on behavioral health, are admission guidelines for behavioral health services delivered to children in their homes, schools, and daily community activities. The availability of these services is required under the federal ruling titled the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) as specifically described in the section called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Implementation of OBRA ‘89 in Pennsylvania was established through the Medical Assistance Bulletin 1241-90-02 of October 15, 1990. While there has been a strong focus on development and expansion of needed services to respond to children with behavioral health treatment needs in multiple child serving systems, more work is required to regulate use of services. Clearly, with concerns about containing cost while enhancing the efficacy of treatment affecting decisions on service delivery, guidelines are needed to bridge the purpose, function, and expectations of these services with actual service delivery. Up to now, the primary connection has been the determination of medical necessity, in combination with the application of the Child and Adolescent Service System Program (CASSP) principles, and a variously applied understanding of the "Wraparound" philosophy of care. The guidelines and classification system presented in this document and subsequent revisions, provide a basis for admitting children and adolescents to behavioral health services delivered in the home, and school, or elsewhere in the community, under EPSDT, and within the context of multiple child serving systems. For ease of reading in the text which follows "child" will refer to both child and adolescent unless otherwise stated.

CASSP principles and the Wraparound philosophy of care provide the foundation supporting the effort to provide mental and behavioral health services to children in their homes and communities. It is understood here that home/community delivered services are not simply intended to be a replacement for all other clinic and hospital based services. These relatively
new services are to address the increasingly complex needs of children receiving services in multiple child serving systems (i.e.- child welfare, juvenile justice, education, mental retardation, and drug & alcohol) and offer an alternative to some of the functions clinic/hospital based services have previously played, because home/community delivered services are considered more appropriate to specific tasks of directed treatment.

Home/community delivered behavioral health services are specifically appropriate for children and adolescents who require intervention at the sites where their problematic behaviors occur. This eliminates the necessity to understand and treat problems, behaviors, or activities in an abstract form dissociated from their actual occurrence, and allows direct intervention. In this way the clinician observes and learns directly from the child's behavior in the natural context, but it also allows the child and clinician to formulate together the language and symbolic references to the problem and the strategies for resolution. Thus the interaction between the child and clinician is not dependent on first understanding an abstract expression of the problem, and allows the child to firmly establish the practicality of the therapeutic intervention. The clinician is not solely dependent on informants and the child receiving treatment for information, nor does the child need to transfer change which occurs in the clinic or institutional setting to the family or community setting where the problem primarily manifests.

The purpose for any recommended service must be justified and clearly stated whether they are clinic or home based. Also, the recommendation for services must carefully consider not only treatment for an identified problem, but the child's multi-system involvement, willingness to engage in treatment, the confidentiality concerns of both the child and family, and whether safety issues require a certain level of restrictiveness in the treatment planning for a particular child or adolescent. Making the decision for the type and level of service is not always easy, but the rationale for the decision made is necessary. Building the rationale requires the appropriate diagnostic and life domain assessments, treatment and interagency team involvement, and the spirit of building a cooperative effort to enhance the intervention in order to achieve the goals of treatment.

Home/Community Services

The behavioral health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and skill development essential in fostering increasing independence of individuals and families (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). The change in emphasis from providing service to children exclusively in established sites, such as clinics and hospitals, and residential and day treatment centers, to serving children individually where they live, learn and play in the community is reflective of this overall change. These changes are supportive of the wraparound philosophy of care to the extent that these community delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her
natural context through focusing on his/her individualized strengths and needs. More broadly, it promotes the opportunity for family independence from professional treatment and therapeutic supports. Family autonomy in the care of children with special needs may be fostered through skill development and assisting the family in the development of their informal support network. An understanding of the social contexts of the child or adolescent, including school and community as well as home, is essential to determining the appropriate sites for interventions and the resources available. When professional services provide a necessary treatment, the service(s) must be focused on accomplishing a set of goals, and incorporate into the planning the appropriate tapering of the service or the replacement of the service with informal and other non-behavioral health therapeutic supports.

The Office of Mental Health and Substance Abuse Services (OMHSAS) has promoted the development of expanded behavioral health services in response to the need for services delivered to children in natural community settings. In Pennsylvania these services have multiple references including, "EPSDT mental health services", "expanded mental health services," "psychosocial rehabilitative services" and "wraparound mental health services". However, EPSDT refers to more than the services considered in the Level of Care protocols to follow, "enhanced" is a term relative to the services currently offered and therefore not necessarily restricted to community based services, and "wraparound" is a philosophy of care and implementation within which professional services may play a role. For clarity in this paper, the services are called simply by their association with home and community. Other psychosocial rehabilitative services which are offered on provider-site, such as therapeutic summer programs and after-school programs are not incorporated into the protocol for home/community services. It is in the application that home/community services must be medically necessary, adhere to the requirement of EPSDT service provision, and should be consistent with the wraparound process.

Treatment objectives may be characterized in at least three ways, individualized, generalized, and service specific. Individualized objectives for the child and family must be created as part of a treatment process which is strengths-based and developmentally appropriate. The generalized objectives reflected in the admission guidelines for clinic and hospital based services are as follows: ameliorate symptoms such that less restrictive and/or less intrusive services can be planned and introduced; stabilization of medical regimen for children requiring psychotropic medication which helps them to effectively receive the least restrictive/least intrusive services possible; promotion of psychosocial growth and development and prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance; coordination of the treatment and discharge plan on an ongoing basis with the appropriate agencies to provide the necessary natural community based supports; and increase in age-appropriate interactivity in a variety of settings [see "Community Integration Questionnaire" in Reference Form D (p. 27)]. Some objectives more specific to the home/community services have been mentioned above, such as: development and practice of interpersonal skills as necessary to enhance parent/child, child/adult, and child/peer relations; identification of personal, family and community resources and exploring their usage; and directly relating
therapeutic aims with social contexts and laying the groundwork for treatment which references
the problem (a higher level of abstraction) such as occurs in clinic based treatment.

Home and community services are developed and tailored specifically to meet
individualized child and family needs (see Table 2). Specialized therapeutic services on the
Medical Assistance fee schedule are: Mobile Therapy, Behavioral Specialist Consultant
(Doctoral Level), Behavioral Specialist Consultant (Master's Level), Therapeutic Staff Support
(TSS), and Summer Therapeutic Activities Program. Each of the first four services is distinct
and described in Medical Assistance Bulletin 01-94-01, issued January 11, 1994 on "Outpatient
Psychiatric Services for Children Under 21 Years of Age." The last is a new program which is
described in Medical Assistance Bulletin 50-96-03, issued April 25, 1996. All of these services
are provided for the purpose of improving and developing the capacity of the treated child or
adolescent, and the family, thereby contributing toward the independence of the family as a unit.
The need for these services will vary according to the severity of the child's problems and the
richness of the resources of the child, the family, and the community.

In this edition of the guidelines for behavioral health home/community services, guidelines
for the delivery of home and community behavioral health services to children with mental
retardation have been added. The Office of Mental Retardation supports the provision of
services in homes and communities. These behavioral health services provide discrete short
term, goal oriented rehabilitative interventions to children with mental retardation. The
availability of these services helps to ensure that children with mental retardation receiving
mental retardation services have access to additional therapeutic interventions when medically
necessary and to assist them remain in their communities.

The structural changes in the behavioral health system are reflected in the development of
the Child and Adolescent Service System Program (CASSP) and its philosophy. Within the
body of this Bulletin is emphasized the importance of consistency in the services with the
CASSP principles. The OMHSAS summary representation of the CASSP principles, is provided
below.

CASSP Principles

The CASSP philosophy of collaborative service delivery to children, adolescents and their
families undergirds all treatment methods. CASSP involves all child-serving systems including
mental health, mental retardation, education, special education, children and youth services,
drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also
include informal community supports and organizations. This philosophy is essential to making
decisions to provide treatment for children. It is also the foundation that motivates the
development of these guidelines. These principles are represented in the following six summary
statements:

1. **Child-centered** - Services are planned to meet the individual needs of the child, rather than
to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) **Family-focused** - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) **Community-based** - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) **Multi-system** - Services should be planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) **Culturally competent** - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) **Least restrictive/least intrusive** - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the home/community delivered services for which "Admission Guidelines" are provided below, can be understood as components within a wider network of service options.
CLASSIFICATION SYSTEM:

Because the collective of home/community behavioral health services is appropriate to treat the full range of symptom severity, an organizational system for associating intensity of service with severity of need is essential. This is different from the current clinic and hospital based services which associate the individual service with the severity of need, such that inpatient hospitalization is associated with higher severity of symptoms than that of partial or outpatient. By dividing the community delivered services into four levels of intensity from least to most, these services roughly parallel the four traditional categories of clinic and hospital based services: Outpatient; Partial Hospitalization; Residential Treatment; and Inpatient Hospitalization. Services are further divided into two types: treatment and therapeutic support. With intensity of service defined by the amount of time the service is provided, as related to the type of service provided, the four levels of home/community delivered services may be identified as contiguous segments along a continuum of intensity.

The first of the four levels describes the criteria for the children with the least severe need who are eligible for the service. Each of the successive levels represents an increase in the severity level for which it is designed. Criteria for children with mental retardation are identified in the first two levels only with the recognition that if these children display greater severity in their symptomatology they may receive an axis I diagnosis. Because all of the home/community delivered services are available for each of the levels, the variation in intensity must be ranked by how much service is delivered. Time is selected as a general measure of quantity for each of the levels, because it is already used in this way to determine payment when a rate is assigned to the service. At this writing, the range of hours for each of the levels is not identified, however the levels represent a proportional relationship between both, the identified levels of severity and the range of services within each.

There are a maximum of four components to each of the levels. In order of presentation in the guidelines and the table: the first part identifies the type and extent of the emotional and behavioral disturbance, including the degree of endangerment; the second requires assurance that the child or adolescent and the family is amenable to treatment in community settings; while the third assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation based on an initial assessment of need which needs greater clarity. As the two highest levels involve a higher severity of symptoms, "observation" for the purpose of determining the problem does not apply. Differentiation between the levels rests primarily with the severity of the problem, and the ability to treat in the community but it also includes the risk of endangerment allowed. More care is required of the assessment of endangerment, but the other categories solicit the psychiatrist or psychologist to elaborate their justification. The usual process for determining improvement or relapse and identifying service and therapeutic support needs, should guide the use of the services.
Using a continuum of severity expresses schematically the importance of allowing children to flow from one category to another as indicated by the child's needs (see Table 2, below). However, suggesting discrete categories with fixed ranges may be interpreted in a manner contradictory to the value of a continuum in providing fluidity. The association of fixed ranges of time with each level is complicated by the potential mix in the available array of services such as clinic based services, services from other child serving systems, or the inclusion of informal family and community supports. These issues beg the question of whether the severity levels may be so firmly attached to the hours of service that a child associated with one level must "officially" be reduced to another level, in order to reduce the hours of home/community based services; though the "true" severity level is higher, and the child, in truth continues to receive a high number of hours of service, but from other sources. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. However, the usual application of admission guidelines is to structure the use of a specific service or service category, and that is the exercise here. The establishment of a recommended range of hours for the delivery of home/community services is not addressed, except to suggest an adjustable range of times depending on the other services used or functions served by family members, and that there is a proportional increase in the expectation of the maximum amount of service within each category.

For the purpose of establishing a reasonable framework, it will be assumed that the hours assigned do not consider the complicating factors of other services and other therapeutic supports, or temporary reductions of service to assess progress. The next task will be to set up a system of values for any additional services and therapeutic supports which can be used as weights to identify a child with the appropriate level.

GUIDELINE FORMATION:

Working toward furthering consistency between children's treatment needs and the broader philosophy of individualized service delivery in the most appropriate manner, is a complex task. Generalizing work such as, the principles of the Child and Adolescent Service System Program (CASSP), the values presented in a variety of CASSP publications, and the wraparound philosophy of care, provide a theoretical basis, and though this body of work has much room to grow, it is time to develop the tools of implementation. The work of admission guidelines for home/community based services is an important beginning to provide a unified basis for decision-making. It is one of the essential instruments needed for behavioral health providers, case managers, interagency teams, and third party payers (including Managed Care Organizations and their sub-contractors), to coordinate service determinations among themselves and with families (including friends and community services as appropriate). Such coordination is vital to foster confidence in the appropriateness of admissions to any of the recommended treatment modalities, as well as continued stay, and appropriate discharge planning.

Inherent in these guidelines is a framework for implementing the wraparound concept in
service delivery and developing discrete individualized service programs. Individualized treatment plans may coordinate a number of services but importantly, the functions of the services must be identified so that they build upon actual strengths, actual needs are addressed by the services. It is also important to help develop family and community resources to meet these needs. Traditional outpatient and partial hospitalization services are examples of other services which may be coordinated with home/community delivered services when medically necessary. Home/community treatment is for children who: may be effectively treated at home; who require comprehensive wraparound planning for transition from a more restrictive setting back to the home and community; who may require a treatment support system while in the community until an effective family and community support network can be activated. These services provide a full range of intensity to the child in his/her natural setting, depending on the evaluated need of the child. In considering the intensity of home/community service, delivery involves three basic elements of consideration: severity of presenting problem, appropriate intensity of service, and the least restrictive and/or intrusive service necessary. These elements are considered separately below.

Severity of Symptoms

Symptom severity is often more apparent to the clinician than it is easy to describe. Levels with identifiable indicators can make the process of assessing severity easier. Additional descriptive information remains important to provide clarifying documentation in the child or adolescent's record. Each of the four levels represented in these guidelines requires an assessment of the child's expression of emotional and behavioral disturbance in any of the following categories for consideration in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Also important is an assessment of the impact of any disturbance on social skill development and the relationship between them. Gaging the severity of any of these presenting symptoms is ultimately left to the judgement of the clinician in his or her review. If severity is otherwise linked to endangerment or imminent risk of out-of-home or out-of-school placement, descriptors may be crafted to indicate relative severity. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must be considered when determining an appropriate treatment design involving home/community services, or any combination of home/community and the more conventional services. The severity of presentation determines the extent of service need. The severity of expression for a child with mental retardation must be evaluated in relation to the individual child’s behavioral norm or “baseline.” The design of the treatment plan must also consider the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the home/community services available for children (see Table 1). But because different treatment plans call for different combinations of services to treat a variety of children or adolescents who could be assessed at
the same level of severity, intensity is associated with a multiplicity of service options and gauged by the amount of total service time needed. However, one division has been made, establishing two tiers of service based on the professional level of the service. The first is "home/community professional behavioral health services," such as Mobile Therapy and Behavioral Specialist Consultant, and the second is "home/community behavioral health implementation-therapeutic support services," such as Therapeutic Staff Support (TSS) and Therapeutic Staff Support Aid (TSSA). The professional services are those performed by highly credentialed individuals who also play a critical role in the development of the treatment plan. Therapeutic support services require personnel who have specific training and a Bachelor's degree or, for TSSAs, a High School diploma. Their role is to assist the child or adolescent, and the family, in the follow-through of the treatment plan.

Of the four severity levels, the last two listed are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any in-patient or out-of-home placement. Highly intensive community delivered treatment is often needed to prevent out-of-home placement, and/or to help children to return to their natural home, school, and community from an out-of-home placement. This works by directly associating the therapeutic process of treatment with effective adaptation to the social environment. The first two severity levels allow a lower range of service intensity to assist the child and family. All the levels provide treatment, but they also encourage the family's developmental process in unassisted interaction. The therapeutic function and emphasis of each of the four service levels depends strongly on the cohesiveness of the interagency and treatment teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for the effectiveness of the treatment plan developed.

Least Restrictive/Least Intrusive

Structural differences between the two kinds of services allow each to be scaled differently along the CASSP principle of providing the least restrictive and least intrusive services necessary. The site-based services, clinics and hospitals, may be scaled on a continuum of restrictiveness from more to less. Restrictiveness essentially refers to the degree the child or person is separated from the general community and integrated into a treatment community. For off-site delivery of services, or those delivered to individuals in their homes, schools, or other community settings, scaling restrictiveness does not apply. However, these services may be scaled on a continuum of intrusiveness, if intrusiveness is to be understood as the degree to which service is integrated into the natural setting and the lifestyle of the individual(s) served. It is through this understanding that it may be asserted that mental and behavioral health services in the lives of clients are not "natural," but an intervention intended to be time-limited. Of course, depending on the severity of the problem, the network of inclusion/support and the other environmental/ecological factors, the time required for individuals' successful treatment will vary. It is these last three elements which are used to formulate the classification system in the guideline.
Home/community services are generally regarded as the least restrictive service options for children who need intensive behavioral health services. However, by delivering services to children in their homes and communities these services may potentially be the most intrusive. Traditionally, intensive behavioral health services were designed to provide treatment in settings separate from the community, such as inpatient and partial hospitalization settings, residential treatment facilities, and outpatient clinics. This segregation of children from greater community involvement for the period of treatment has become the defining characteristic of restrictiveness and allows consideration of these services on a continuum from least restrictive to more restrictive. Home/community services parallel the intensity available in the traditional services, but because these services engage the child in family and community activities home/community services are not easily characterized as restrictive. However, they may be identified with intrusiveness due to their close involvement with, and presence in the daily activities of the child receiving treatment, and the family.

The four levels for the delivery of the home and community addressed in this bulletin, are presented in ascending order of service intensity and professional intervention. The need for greater or lesser intensity of service must be adjusted to the individual's need for active treatment as reflected in the evaluation and the treatment plan. Increased intensity of service may improve the effectiveness of treatment by providing convenience and opportunity for more responsive intervention. Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the relationship formations of children with their families, peers, and functioning in normalized settings in the community. Also, care must be taken to avoid the development of a dependency relationship between any family members and behavioral health professionals which result in a non-therapeutic alliance. Each service level provides treatment with the object of helping children with acute behavioral problems or serious emotional disturbance to increase their ability to integrate into the community and culture of their respective families by increasing his or her capacity for self control.

ADMISSION GUIDELINES:

Criteria for each level of Home/community service is based on the individual severity indicators. In the admission guidelines described below is a process for deciding when to treat, continue, or discontinue treatment and refer elsewhere for other services. However, the concept of tapering, or systematically reducing the intensity of the services delivered has been added here. The guideline is divided into five (5) sections: I- Diagnostic Evaluation and Documentation; II- Severity Levels and Service Correlates; III- Therapeutic Support Criteria; IV- Continued Care; and V- Discharge and Service Transition. The first three include the evaluation and documentation criteria for Admission, the fourth and fifth are for determining the appropriateness of continuing, tapering, and discontinuing care.

As these guidelines are written, it is assumed that any child or adolescent receiving services has a case manager, that children with mental retardation have a county MH/MR case manager,
and that all children with multiple systems involvement have incorporated into the planning process an interagency team. Concerning the structure of Section II which associates the severity of the presenting problem with four contiguous levels, each level proposes corresponding ranges of hours for both professional behavioral health services and behavioral health therapeutic support services. For the purpose of clarity in the structure, the hours proposed assume there are no other services provided to the individual in treatment. Nor do they carry any presumption of the richness of the home/community therapeutic supports available to the child or adolescent in treatment. However, both the system and community therapeutic supports are critical to the appropriate determination of service hours to be delivered. It is for this reason that Table 2 has been included. This table provides two matrices, one for reviewing the problems of the child and the other for the strengths of the child, family and community. Each lists the possible domains and settings affected. The matrices are designed to help in the decision-making process when determining the appropriate mix of services, and the appropriate adjustment for the amount of the services in each severity level in Section II below. Such determinations should be used and documented as an adjustment of time within the severity level selected, and it is expected that this is a natural part of any interagency or treatment team process.

**Home/Community Services**

**Admission Guidelines**

(Must meet I, II, and III)

Admission of a child for Home/Community Behavioral Health Treatment is most appropriately based on a face-to-face assessment and diagnosis by the prescribing Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these prescribers, a diagnosis may be appropriately provided by any Board Certified or Board eligible psychiatrist or a licensed psychologist. Any time a child or adolescent specialist is unavailable to perform the necessary diagnostic services, this should be documented and explained. As part of the assessment process and the development of treatment recommendations, the prescriber addresses the concerns and recommendations of the case manager and the interagency team.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM). The most current edition in use at this writing is the DSM IV; for ease of reading, the text following will reflect this edition. For further convenience in reading, "child and adolescent" will follow the form of "child", unless otherwise indicated.
I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Mental Health
1. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face evaluation (MR or D&A cannot stand alone);
   AND
2. Evaluation indicates:
   a. child has, or is at serious risk of developing, an emotional or behavioral disturbance, or mental illness; and
   b. clinic based treatment is not sufficient or appropriate to effectively serve the child/family; and
   c. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a psychiatric residential treatment facility; and/or
   d. the child needs home/community mental health treatment as a result of documented emotional and behavioral disturbance of functioning:
      1) within the family or other community-based residential setting, or
      2) in the school setting, or
      3) resulting in limitations in social and community interactions; or
   e. a combination of mental health needs that cannot be met without treatment delivered to the child in the community by mental/behavioral health professionals.
   OR

B. Mental Retardation
1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (MR cannot stand alone), without a diagnosis on Axis I;
   AND
2. Evaluation indicates:
   a. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation; and/or
   b. a notable adverse change in the baseline behavior of a child or adolescent with mental retardation; and
   c. a medical condition has been ruled out; and
   d. existing mental retardation services are no longer sufficient or appropriate to effectively serve the child/family; and
   e. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a residential treatment facility; and/or
   f. the child needs home/community behavioral health treatment as a result of a...
documented behavioral disturbance functioning:

1) within the family, foster care, family living or other community-based setting, or
2) due to behavior which results in limitations in social and community interactions; or

g. a combination of behavioral health needs that cannot be met by existing mental retardation services without treatment delivered to the child in the community by additional behavioral health professionals.

AND

C. Parent(s)/guardian(s), and/or care giver as appropriate, a lead case manager and the child to his/her fullest ability must be involved in the planning process. Where a parent (or legal guardian) or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. The interagency team should otherwise recommend the most appropriate alternatives should home/community service alone be insufficient to serve the child's needs; AND

D. There is:
   1. serious and/or persistent impairment of developmental progression not attributable to mental retardation and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder;
   OR
   2. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation;
   AND/OR
   3. a notable adverse change in the baseline behavior a child or adolescent with mental retardation resulting in significant measurable reduction in psychosocial functioning with respect to the existing developmental disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

   OR

E. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level when developmental level is unrelated to mental retardation;

   OR

F. Behaviors or symptoms improve in response to comprehensive treatment at a higher level of care, but child needs home/community treatment to sustain and reinforce stability;
G. Requires medication, and time limited monitoring of the medications is needed to mitigate the effects of the child's symptoms until the child and/or family can assume this role.

II. SEVERITY LEVELS and SERVICE CORRELATES
(See also Table 1)

Service volume and intensity must be recommended as the most clinically appropriate and least intrusive necessary for the child, by the prescriber, as informed by the interagency team.

(Must meet A or B or C or D)

A. **MH - Level 1** (Least) - DSM IV Axis I/II diagnosis
   (MR or D&A cannot stand alone)
   ____ to ____ hours, of any Home/Community Professional Mental Health Services
   ____ to ____ hours, of any Home/Community Mental Health Therapeutic Support Services
   (Must meet 1, 2, and 3; OR 4)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the case manager and interagency team, and

   a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder other than mental retardation, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; or

   b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level, require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission and/or to promote effective adaptation; or

   c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; or

   d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a
pattern of following the prescription;
   AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and
   b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan;

   AND

3. The severity and expression of the child's symptoms are such that:
   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
   b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

   OR

4. OBSERVATION

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II AND/OR recommend development of a transition plan. Should it be found that the child does not fit the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

   a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
      - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; or
   
   b. Child's symptoms have not sufficiently improved despite well-planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.
A. MR - Level 1 - DSM IV Axis II/IV diagnosis
(MR cannot stand alone)
__ to __ hours, of any Home/Community Professional Behavioral Health Services
__ to __ hours, of any Home/Community Behavioral Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for
   the child, by the prescriber as informed by the lead case manager and interagency
   team, and
   
a. There is significant change or amplification in exhibited behaviors as indicated by
      an increase in frequency (average number of events per day), duration (after first
day, the increase in number of consecutive days), and/or locations; and
b. Behavior presents serious risk of self injury, or injury to others, or destruction of
   environment; and
  c. Significant psychosocial stressors are present affecting a decrease in the child's
     functioning; and/or
  d. Requires medication and home/community based monitoring of medications to
     help the child (and family) understand the importance of adhering to the therapy
     recommended to mitigate the effects of the child's symptoms, and establish a
     pattern of following the prescription; AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is
   assessed to be responsive to the implementation of a community-based treatment
   plan in the professional judgment of the appropriate behavioral health
   professional, as a result of:
   
a. the delivery of the professional care required to serve the child's specific
   treatment occurring on site; and
b. there is documented commitment by the primary care givers (usually
   parent/guardian) to the treatment plan;
   AND

3. The severity and expression of the child's behaviors are such that:
   
a. continuation with a less intense level of care cannot offer either an expectation
   of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective
   preventive approach to longer term consequences.
B.  **MH - Level 2 - DSM IV Axis I/ II diagnosis**  
(MR or D&A cannot stand alone)  
__ to __ hours, of any Home/Community Professional Mental Health Services  
__ to __ hours, of any Home/Community Mental Health Therapeutic Support Services  
(Must meet 1, 2, and 3; or 4)

1. Risk of child harming him/herself or others, or causing destruction to property, is assessed low in the child's current problematic behavioral or functional impairment; presenting history and psychiatric examination, **and**

   a. Must include at least one (1) of the criterion below:
      1) Suicidal/homicidal ideation  
      2) Impulsivity and/or aggression  
      3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)  
      4) Psychomotor retardation or excitation  
      5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)  
      6) Psychosocial functional impairment  
      7) Thought Impairment (i.e.- psychosis)  
      8) Cognitive Impairment;  
      and/or  

   b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level which is not attributable to mental retardation such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised;  
   **AND**

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; **and**  
   b. documented commitment by the primary care givers usually parent/guardian to the therapeutic plan;  
   **AND**

3. The severity and expression of the child's symptoms are such that:

   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; **and**  
   b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.  
   **OR**
4. **OBSERVATION:**

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II AND/OR recommend development of a transition plan. Should it be found that the child does not meet the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but, - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; or
b. Child's symptoms have not sufficiently improved despite well planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

**MR - Level 2 - DSM IV Axis II/IV diagnosis**  
(MR cannot stand alone)  
__ to __ hours, of any Home/Community Professional Behavioral Health Services  
__ to __ hours, of any Home/Community Behavioral Health Therapeutic Support Services  
(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, and

a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; and  
b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; and  
c. Significant psychosocial stressors are present affecting a decrease in the child's functioning or an escalation of the child's symptoms; and/or  
d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a
pattern of following the prescription;
AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; and
   b. there is documented commitment by the primary care givers (usually parent/guardian) to the treatment plan;
   AND

3. The severity and expression of the child's behaviors are such that:

   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
   b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

C. **MH - Level 3 (Intensive)**

   _to_ hours, of any Home/Community Professional Mental Health Services
   _to_ hours, of any Home/Community Mental Health Therapeutic Support Services

   (Must meet 1, 2, and 3)

1. Severe functional impairment discussed in the presenting history and psychiatric examination, is assessed in the child's problematic behavior in home, school or community, and there is risk of an out-of-home or out-of-school placement. In addition, there may be risk of danger in child harming him/herself, harming others, and/or demonstrated destruction to property; and

   a. Must include at least one (1) of the criterion below:
   
   1) Suicidal/homicidal threats or intensive ideation
   2) Impulsivity and/or aggression
   3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
   4) Psychomotor retardation or excitation.
   5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
   6) Psychosocial functional impairment
   7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; and/or,

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and

b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; and

c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and

b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

D. MH - Level 4 (Highly Intensive)

__ to __ hours, of any Home/Community Professional Mental Health Services
__ to __ hours, of any Home/Community Mental Health Therapeutic Support Services

(Must meet 1, 2, & 3)

1) The severe functional impairment discussed in the presenting history and psychiatric examination is assessed in the child's problematic behavior in home, school or community and there is a high risk of an out-of-home or out-of-school placement, or a resumption of out-of-home/school placement for a child transitioning back to home or school. In addition, there may be demonstrated risk of endangerment involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness;
a. Must include at least one (1) of the criterion below:

1) Suicidal/homicidal threatening behavior or intensive ideation
2) Impulsivity and/or aggression
3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4) Psychomotor retardation or excitation.
5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6) Psychosocial functional impairment
7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; and

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised; AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; and
b. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan; and
  c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

### III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF SYMPTOMS or BEHAVIORS. There must be family commitment to the treatment
process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

A. Child must be reevaluated and continue to meet criteria for admission (Section I); AND

B. Child shows:
   1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); or
   2. increased or continued behavioral disturbance with continued expectation for improvement (show rationale in the treatment plan); AND

C. Treatment plan is addressing the behavior within the context of the psychosocial stressor(s)/event(s); AND

D. Interagency service plan recommends continuation of care.

The child/adolescent must meet Admission Criteria for Section II, Level 3 or lesser levels of severity. Whenever service is provided for a term greater than three (3) months, there must be a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing Home/community service rather than another service appropriate to the child's needs or discharge from behavioral health services altogether. The Interagency Service Plan must be updated and attached to the Treatment Plan.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. Mental Health
   Prescriber, with the participation of the interagency team, determines that home/community service:
   1. results in an expected level of stability and treatment goal attainment such that no additional home/community services are necessary and discharge occurs; OR
   2. should be maintained as follows:
a. continued at the current level; or
b. continued with a reduced number of hours as a result of the child’s improvement, and/or the child's network of family and friends, and/or the activity of community members and services; or
c. increased due to changes in the context and/or adjustments in the treatment plan;

OR

3. ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community mental health services; OR

4. interferes with the development of a service-independent lifestyle, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created; OR

5. A child admitted under Section IIB only, of the ADMISSION Guidelines must be discharged within fifteen (15) days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section IIA; OR

B. Mental Retardation
Prescriber, with the participation of the interagency team, determines that home/community service:
1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. baseline behavior, or
   b. expected positive behavioral response, and/or
   c. that no additional home/community services are necessary;

   OR

2. should be:
   a. discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; or
   b. continued with a reduced number of hours as a result of the child’s improvement, and/or the child's network of family and friends, and/or the activity of community members and services; or
   c. increased due to changes in the context and/or adjustments in the treatment plan;

   OR

3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
OR

C. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.
BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT:  
Home/Community Services

**TABLE OF SECTION II SEVERITY LEVELS AND SERVICE CORRELATES**

*WITH CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS*  
* (All Services Are to Be Determined On an Individual Basis for the Child or Adolescent)*  

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites, such as After-school and Summer Therapeutic Activities Programs)

<table>
<thead>
<tr>
<th>Level 1 (Least)</th>
<th>Level 2 (Moderate)</th>
<th>Level 3 (Intensive)</th>
<th>Level 4 (Highly Intensive)</th>
</tr>
</thead>
</table>
| 1 to _ hours of Professional & 1 to _ hours of Therapeutic Support Services  
(Must meet A, B, & C; OR D) | _ to _ hours of Professional & _ to _ hours of Therapeutic Support Services  
(Must meet A, B, & C; OR D) | _ to _ hours of Professional & _ to _ hours of Therapeutic Support Services  
(Must meet A, B, and C) | _ to _ hours of Professional & _ to _ hours of Therapeutic Support Services  
(Must meet A, B, and C) |

**I. & II. [Combined] DIAGNOSTIC INDICATORS BY LEVEL**

A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the interagency team, and

A. Risk of harming [self, others, or property] is assessed low in the child's current problematic behavior or functional impairment and presenting history; and psychiatric or psychological examination must include:

A. Severe functional impairment is assessed in the child's problematic behavior in the home, school, or community; there is risk of an out-of-home or out-of-school placement; may be risk of danger of child harming him/herself, others, and/or demonstrated destruction to property; and

A. High risk of out of home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; and/or the severe functional impairment in the home, school, or community, and
<table>
<thead>
<tr>
<th>Level 1 (Least)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Children with a Diagnostic Indicator on AXIS I</strong></td>
<td><strong>a.</strong> Assessment of at least one (1) of the following:</td>
<td><strong>a.</strong> Assessment of at least one (1) of the following:</td>
<td><strong>a.</strong> Assessment of at least one (1) of the following:</td>
</tr>
<tr>
<td>1. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors;</td>
<td>1. Suicidal/homicidal ideation</td>
<td>1. Suicidal/homicidal threats or intensive ideation</td>
<td>1. Suicidal/homicidal threatening behavior or intensive ideation</td>
</tr>
<tr>
<td>or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission;</td>
<td>2. Impulsivity and/or aggression</td>
<td>2. Impulsivity and/or aggression</td>
<td>2. Impulsivity and/or aggression</td>
</tr>
<tr>
<td>or</td>
<td>3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</td>
<td>3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</td>
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<tr>
<td><strong>or</strong></td>
<td>4. Psychomotor retardation or excitation</td>
<td>4. Psychomotor retardation or excitation</td>
<td>4. Psychomotor retardation or excitation</td>
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<tr>
<td><strong>and/or</strong></td>
<td>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</td>
<td>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</td>
<td>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</td>
</tr>
</tbody>
</table>
### TABLE 1

<table>
<thead>
<tr>
<th><strong>Level 1 (Least)</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>b.</strong> Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission; <strong>or</strong></td>
<td><strong>b.</strong> Presence of very impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised, are not attributable to mental retardation;</td>
<td><strong>b.</strong> There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised, are not attributable to mental retardation;</td>
<td><strong>b.</strong> There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised, are not attributable to mental retardation;</td>
</tr>
<tr>
<td><strong>c.</strong> Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reenforce stability; <strong>or</strong></td>
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<tr>
<td><strong>d.</strong> Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;</td>
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Commonwealth of Pennsylvania  
HealthChoices Behavioral Health  
Program Standards and Requirements - Primary Contractor – County  
January 1, 2005
<table>
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<tr>
<th>Level 1 (Least)</th>
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<tbody>
<tr>
<td>AND/OR</td>
<td>AND/OR</td>
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</table>

**2. Children with a Diagnostic Indicator on AXIS II (without a diagnosis on Axis I) (Levels 1 & 2)**

- **a.** There is an onset of remarkable behaviors which could escalate to a crisis

- **b.** Behavior presents serious risk of self injury, or injury to others, or destruction of environment; *and*

- **c.** (Levels 1 & 2) There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); *and/or*

- **d.** (Levels 1& 2) Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child’s age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;
<table>
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</table>

**B.** (All levels) Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:

1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; and
2. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan. and
3. (Level 3) if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs.

**C.** (All levels) The severity and expression of the child's symptoms are such that:

1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

**AND**
TABLE 1

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<tr>
<td><strong>D. OBSERVATION- 15 days (Levels 1 &amp; 2)</strong></td>
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<tr>
<td>1. Troubling symptoms of the child (described by family/ school/ others) persist though</td>
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<tr>
<td>- not observed on a psychiatric inpatient unit, <strong>or</strong></td>
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<tr>
<td>- they are denied by the child in outpatient or partial hospitalization treatment, <strong>such that</strong> observation of the child in natural settings provides the opportunity to assess and treat the child; <strong>OR</strong></td>
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<tr>
<td>2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.</td>
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<tr>
<td><strong>III. SUPPORT CRITERIA</strong> (All levels)</td>
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<td></td>
</tr>
<tr>
<td>The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/adolescent's network of personal, family, and community support.</td>
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<td><strong>IV. CONTINUED CARE</strong> (All levels)</td>
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<tr>
<td>Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.</td>
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<tr>
<td>(All levels)</td>
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</tr>
<tr>
<td>1. Child must be reevaluated and continue to meet criteria for admission (I); and</td>
<td></td>
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<tr>
<td>2. Child shows:</td>
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<tr>
<td>a) measured improvement and/or begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); or</td>
<td></td>
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<tr>
<td>b) increased or continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan); and</td>
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<tr>
<td>3. Review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.</td>
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<tr>
<td>4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s); indicating that service should be:</td>
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<tr>
<td>a) continued with a reduced number of hours as a result of the amelioration of original indication for service, and/or activity of community members and services, and/or the child's network of family and friends; or</td>
<td></td>
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<tr>
<td>b) increased due to changes in the context and/or adjustments in the treatment plan; and</td>
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<tr>
<td>5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan</td>
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</tbody>
</table>
## V. DISCHARGE CRITERIA (All levels)

<table>
<thead>
<tr>
<th>A. Prescriber, with the participation of the interagency team, determines that home/community service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:</td>
</tr>
<tr>
<td>a. baseline behavior, or</td>
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<td>b. expected positive behavioral response, and/or</td>
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<tr>
<td>c. that no additional home/community services are necessary;</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>2. should be discontinued because it <em>ceases to be effective</em>, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services;</td>
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<td><strong>OR</strong></td>
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<td>3. the services provided <em>create a service dependency interfering with the development of the child's progress toward his/her highest functional level</em>, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;</td>
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<tr>
<td><strong>OR</strong></td>
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</tbody>
</table>

| B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service. |
### Matrix of Current Problems

<table>
<thead>
<tr>
<th>Domain</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>Behavioral</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
</tr>
<tr>
<td>Cognitive/Learning</td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td></td>
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<tr>
<td>Leisure</td>
<td></td>
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<tr>
<td>Unique/Other</td>
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</tbody>
</table>

### Matrix of Current Strengths

<table>
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</table>

**REFERENCE FORM A**

Commonwealth of Pennsylvania  
HealthChoices Behavioral Health  
Program Standards and Requirements - Primary Contractor – County  
January 1, 2005
Expectations for All Individualized Community Based Enhanced Mental Health Services:

Individualized community based enhanced mental health services can be used in the home, community, or school, separately or in combination, as medically necessary. The child’s emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgement, insight, impulse control, psychomotor retardation/excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school, and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of individualized community based enhanced mental health services, other child serving systems and/or traditional mental health services.

The following represent specific expectations regarding the utilization of all individualized, community based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.

- Each proposed or utilized mental health service has a clearly documented rationale, with a specific role in addressing the child’s medically necessary needs. Services, separably and in combination, constitute the least restrictive and least intrusive services which are medically necessary.

- Service decisions are substantially determined by an interagency process based on child-driven needs.

- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing child’s development in multiple life domains.

- Ongoing efforts are being made to utilize community resources, whenever possible.

- Parents and guardians have requested or otherwise support the use of proposed services.

- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan with active participation by parents, guardians, and other responsible adults.

- Treatment involves teaching and support of efforts by parents, guardians, and other responsible adults, and those activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.
- Treatment involves ongoing integrated and supervised efforts by all service providers, which includes a lead case manager.

- Potential medication needs are being addressed or considered.

- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team prior to either an increase or decrease of services or change in level of services.

- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed with the interagency team.
REFERENCE FORM B

Function of Home/Community Services

- Provision of services which are less restrictive, more flexible yet effectively provides therapeutic supports for patients discharged from in-patient, residential treatment facilities, or partial hospitalization. In this way home/community services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more restrictive or higher level of services. To help the child develop the necessary self-control, and/or capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require treatment directly in the setting where symptoms typically manifest, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after-school service for children with mental and/or psychosocial disorders, so that:
  - parents/guardians can develop the behavioral patterns necessary to provide the additional support necessary to maintain a therapeutic environment for the child;
  - parents/guardians can receive family therapy consistent with the treatment of their child.

Should service involve a child removed from school during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic evaluations, medical and psychiatric treatment, and psychosocial rehabilitation. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is desired but not possible the reasons must be clearly documented.
Treatment Range- Home/community treatment varies in intensity, duration and purpose. Intensity may be reflected in the number and length of visits as well as the professional level of the service. The duration and types of service offered will vary according to the severity of the child's symptomatology and the complexity of the intervention required as described in the treatment plan. The range of service includes therapeutic support identified in four levels corresponding with the levels of severity established for Severe (but Inpatient Treatment not required), Residential Treatment Facility, Partial Hospitalization, and Outpatient Treatment, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to, or maintain the child in a stable condition. Home/community treatment may serve as a step-down from inpatient treatment, a residential treatment facility, and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the therapeutic support of short term services to ameliorate the presiding condition or stress.
REFERENCE FORM C

Continued Stay Service Documentation
For Mental Health Services

The following list of information should be documented for the four service levels.

1. Routine evaluations and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge guidelines formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary therapeutic supports for the child's successful transition into the community, including mental health, substance abuse, mental retardation and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to less intrusive and non-restrictive services.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and through working with an interagency team forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.
11. The provision of services supports the child's involvement in age appropriate activities and interests as outlined in the treatment plan.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan and/or plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization must be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.
REFERENCE FORM D

Community Integration Questionnaire

1. Are the child's interest areas? and strengths? documented, with a plan to explore new interests and strengths for the child?

2. Have the child's community and family support network, and cultural resources been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been recruitment of family members, or other significant individuals, to participate as designated support persons

4. Do you have a list of the available services, events and activities in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been involved in over the past two months? Is there a plan to continue this involvement?

6. Does the treatment plan include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extracurricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:
   - staff oversight of planned parental supervised activities?
   - staff supervised activities for parent/child interaction?
   - for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a plan of reinforcement for a child's successful participation outside of the treatment setting? and a crisis intervention plan for the child while outside of the treatment setting?

8. Do the progress notes detail the outcome of the home/community integrative activity?
9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?
Bibliography

American Psychiatric Association

Commonwealth of Pennsylvania


INTRODUCTION:

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

These Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and their families for this service. [See FBMHS program standards in State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(l), available in the HealthChoices Proposers' Library].

PROGRAM PHILOSOPHY & ORGANIZATION:

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a
resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three year period designed specifically for Family Based Mental Health Service Team members.

The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child’s treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;
- Emergency availability;
- Ongoing information-gathering in support of active treatment;
- Collaborative development and modification of the treatment plan;
• Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child’s symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;

• Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;

• School-based consultation and intervention as needed;

• Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;

• Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child’s treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child’s treatment goals.

The FBMHS budget identifies administrative and program costs which include family support services.

• The FBMHS unit of service is billed for activities or direct services which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.
There is no separate reporting requirement for FBMH Family Support Services.

The provider must have an accounting system that identifies revenue sources and expenditures.

ADMISSION CRITERIA
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55, Public Welfare § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));

AND

B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child’s and the family’s condition;

OR

Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child’s and the family’s condition;

AND

C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS
A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND
1. the family recognizes the child’s risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

   AND/OR

2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;

   AND

B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

   1. Suicidal/homicidal ideation
   2. Impulsivity and/or aggression
   3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
   4. Psychomotor retardation or excitation.
   5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
   6. Psychosocial functional impairment
   7. Thought Impairment
   8. Cognitive Impairment

   AND

C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

   AND

D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;

   OR
E. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;

OR

F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

OR

G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

REQUIREMENTS FOR CONTINUED CARE
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION
A. Recommendation to continue FBMHS must occur:
   1. by the treatment team every 30 days through an updated and revised treatment plan, and
   2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;

   AND

B. There is significant family (including the child) cooperation and involvement in the treatment process.

   AND

C. An updated treatment plan by the treatment team indicates child’s progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.
II. SEVERITY OF SYMPTOMS
   A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;  
      OR

   B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;  
      OR

   C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.

III. SUPPORT CRITERIA
    The on-site clinical expertise necessary must be available as appropriate to the severity of behaviors. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION
    A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.
       1. The review of the child being served must:
          a) clarify the child's progress within the family context and progress toward developing community linkages; and
             1) clarify the goals in continuing FBMHS; and
             2) the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
          b) whenever FBMHS service is considered for a term greater than 32 weeks:
             1) a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
             2) review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

    B. Child demonstrates:
       1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); or
2. increased or continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan); and

C. Treatment plan is addressing the behavior within the context of the child’s problem and/or contributing psychosocial stressor(s)/event(s); and

D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES
A. The treatment team, determines that FBMHS:
   1. up to 32 weeks of FBMHS services has been completed; and/or
   2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
      a) expected behavioral response, and/or
      b) the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
   3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
   4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created; OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.
TABLE OF FAMILY BASED MENTAL HEALTH SERVICES PROGRAM ADMISSION CRITERIA

<table>
<thead>
<tr>
<th>Family Based Mental Health Services</th>
<th>(Must meet I/II and III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. &amp; II. [Combined] DIAGNOSTIC INDICATORS</td>
<td>[Axis I or Axis II; D&amp;A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C &amp; D)</td>
</tr>
<tr>
<td>A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down from inpatient hospitalization or Residential Treatment, <strong>or</strong> as a result of little or no progress in a less restrictive/intrusive service,</td>
<td></td>
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<tr>
<td>AND</td>
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<tr>
<td>B. Severe functional impairment is assessed in the child’s presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.</td>
<td></td>
</tr>
<tr>
<td>1. There is serious <strong>and/or</strong> persistent impairment of developmental progression <strong>and/or</strong> psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms <strong>and/or</strong> behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms <strong>and/or</strong> behaviors which are in partial or complete remission;</td>
<td></td>
</tr>
</tbody>
</table>
### Family Based Mental Health Services
(Must meet I/II and III)

2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and
   a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family; and/or
   b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;
   and

3. Presence of at least one (1) of the following:
   a. Suicidal/homicidal threatening behavior or intensive ideation
   b. Impulsivity and/or aggression
   c. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
   d. Psychomotor retardation or excitation.
   e. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
   f. Psychosocial functional impairment
   g. Thought Impairment
   h. Cognitive Impairment
   and

4. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;
   and

5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;
   and
### Family Based Mental Health Services

(Must meet I/II and III)

| 6. | Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level; |
|  | or |
| 7. | Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community. |

**AND**

**C.** Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:

| 1. | the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs; |
|    | and |
| 2. | there is documented commitment by the family to the treatment plan |
|    | and |
| 3. | if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a safety plan which, the family member signs. |

**AND**

**D.** The severity and expression of the child's symptoms are such that:

| 1. | continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; |
|    | and |
| 2. | on-site intervention in the home or community offers a more effective preventive to longer term consequences. |
### III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

### IV. CONTINUED CARE

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

#### A.

The review of the child being served must:

1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
   a. clarify the goals in continuing FBMHS; and
   b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; and
2. whenever FBMHS service is considered for a term greater than 32 weeks:
   a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; and
   b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

#### B.

Treatment plan is updated to reflect the recommendation to continue care.

#### C.

Treatment plan is addresses the presenting problem within the context of the family and/or contributing psychosocial stressor(s)/event(s); and
Family Based Mental Health Services
(Must meet I/II and III)

D. Child demonstrates:
   1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);
   
   or

   2. increased or continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that:
   1. Up to 32 weeks of FBMHS services has been completed; 
   
   and/or

   2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
      a. expected positive behavioral response; and/or
      b. FBMHS are no longer necessary in favor of a reduced level of support provided by other services; 
   
   or

   3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services;
   
   or

   4. the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
   
   or

   AND

B. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

CHILD/ADOLESCENT TARGETED CASE MANAGEMENT SERVICES

Admission (must meet criteria I and II):

An individual who meets the minimum staff requirements for an Intensive Case Manager or Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 — Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The child/adolescent meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 — Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management.

A child or adolescent who needs to receive targeted case management services but who does not meet the requirements identified above may be eligible for targeted case management upon review and recommendation by the county administrator.

and

II. The child/adolescent is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer

Continued Stay and/or Change of Level of Need (must meet criteria I and II):

The child/adolescent and his/her family and/or guardian, or caregiver/natural support must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual’s situation that warrants a change in level of TCM services.

I. The child/adolescent continues to meet at least 2 out of 3 Admission Criteria.

and

II. The child/adolescent is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.
Discharge Indicators

I. Targeted Case Management may be terminated when one of the following criteria is met:

A. The child/adolescent or family receiving the service determines that targeted case management is no longer needed or wanted and the child/adolescent no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the child/adolescent receiving the service and the child/adolescent no longer meets the continued stay criteria; or

C. The child/adolescent or family receiving the service determines that targeted case management is no longer wanted, even though, the child/adolescent does meet continued stay criteria; or

D. the child/adolescent and family has moved outside of the current geographical service area (e.g., county, state, country).
TCM ENVIRONMENTAL MATRIX — CHILDREN

INSTRUCTIONS

The Environmental Matrix — Children is a scale that evaluates the functional and need levels of children and adolescents who are under the age of 18 years old or who are over 18 years of age but who are still attending a school program. Note: Adolescents age 16 – 22 may be assessed on either the child/adolescent environmental matrix or the adult environmental matrix, depending on the adolescent’s current circumstances. The parent/guardian and adolescent, in discussion with the reviewer, should determine which Environmental Matrix will be used. The child/adolescent and family and/or guardian or care giver/natural support must be assessed in a face to face interview assessment with the evaluator. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals should be reassessed as needed, but no less than every six months. There are ten (10) assessment areas identified in relationship to Targeted Case Management services:

1. Accessing Mental Health Services
2. Informal Support Network Building
3. Education/Vocation
4. Children and Youth System Involvement
5. Juvenile Justice/Criminal Justice System Involvement
6. Parent/Guardian and/or Other Family Members with Significant Family Needs.
7. Drug and Alcohol System Involvement
8. Mental Retardation System Involvement
9. Physical Health System Involvement
10a. At Risk of Out-of-Home Placement

Or

10b. Currently in RTF, Other Out of Home Placements or Inpatient

Please note: Although items 10a. and 10b. both deal with residential placement, scoring is done for only one of the items, either item 10a. or item 10b., since only one of these items can be relevant to the child/adolescent’s current residential status.

The scale has a range from 0 to 5 with the following values for each activity:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No assistance needed</td>
<td>Minimum of assistance needed</td>
<td>Needs moderate assistance in this area</td>
<td>Needs significant assistance in this area</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements - Primary Contractor – County
All ten assessment areas are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the child/adolescent and his/her family and/or guardian, or care giver/natural support. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, resourcefulness and responsibility). The evaluator should consider the child’s/adolescent’s and parent’s/guardian’s (family) strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- Housing/living situation
- Income/benefits/financial management
- Socialization/support
- Activities of daily living
- Medical treatment

Each assessment area is defined at the “1”, “3”, and “5” levels (See attached Environmental Matrix) and the subtotal score is divided by 10 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels may be gradated to the 0.5 level only; this allows for minor differentiation of the child’s/adolescent’s needs without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, and situation of the child/adolescent during the last ninety (90) days, rate the child’s/adolescent’s need for TCM in each of the ten areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the ten (10) scores should then be taken and divided by 10 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. Note: If a particular assessment area does not apply to the individual being assessed, a score should not be given for that assessment area and the total score should be divided by the number of assessment areas scored. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value. The Environmental Matrix score, your professional judgement*, and other information (e.g., cultural factors, records of past treatment, etc.) that impacts on the child’s/adolescent’s level of need should then be considered and the recommended
level of TCM service should be entered on the recommended level of TCM line of the scoring sheet. (These levels are consistent with minimum levels of contact as defined in Chapter 5221, Intensive Case Management regulations and bulletin OMH-93-09, Resource Coordination: Implementation.) If the recommended level of TCM services differs from the Environmental Matrix Score, the difference must be justified with professional judgement in the “Other Factors/Issues Affecting Score” section of the scoring sheet. Note: The level of service indicated by the assessment represents the individuals needs at the time of the assessment. Service intensity could change as an individual’s needs and/or desires for service change.

Please note:

- Although a child/adolescent may not meet the eligibility criteria and/or the Environmental Matrix formulary, inclusive of professional judgement and other information that impacts on the individual's need for the service, he/she may be authorized for Targeted Case Management Services upon the recommendation of the County Administrator and/or designee.

**ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT TCM SERVICE SCORING GRID**

<table>
<thead>
<tr>
<th>MATRIX LEVEL</th>
<th>NEED LEVEL</th>
<th>INTENSITY OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 –5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended).</td>
</tr>
<tr>
<td>1.5 –3.9</td>
<td>RC</td>
<td>At least 1 contact every 30 days (Face to Face)</td>
</tr>
<tr>
<td>0.0 - 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
</tr>
</tbody>
</table>

*professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.*
ACCESSING MENTAL HEALTH SERVICES

Child’s/adolescent’s mental health problems require mental health services and the family requires help to access them. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to assessing services (e.g., language, perceived/actual institutional racism/discrimination, the family may mistrust the behavioral health system, the family may lack the capability to access services, the family may lack information, be overwhelmed, poorly informed about the benefits of such services, or intimidated by the system). The TCM is instrumental in assuring that the child/adolescent receives the necessary services for therapy, medication monitoring, etc.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs minimal assistance in this area</td>
<td>Needs moderate assistance in this area</td>
<td>Needs significant assistance in this area</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.
INFORMAL SUPPORT NETWORK BUILDING

The child/adolescent and parent/guardian identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the child/adolescent may gain informal support. Service system barriers and other factors, however, may impede the child/adolescent and parent/guardian from interacting with family, friends, significant others and community groups. The child/adolescent may need assistance to challenge and remove barriers so as to enhance the informal building of supports. The child/adolescent may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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<td>Child/adolescent is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom he/she interacts and from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.</td>
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<td>Child/adolescent needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.</td>
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<td>Child/adolescent is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. The child/adolescent...</td>
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Appendix T
Part B (4)

has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. The parent/guardian and child/adolescent requires and/or desires significant assistance from others to elicit information and support on his/her behalf.

EDUCATION/VOCATION

The need for additional or more appropriate educational and/or vocational services, based on the needs of the child/adolescent, including a more appropriate educational and/or vocational placement, may require school meetings, IEP meetings, meetings with the Office of Vocational Rehabilitation or other vocational planning or service groups (e.g., vocational service providers), advocacy for the child’s/adolescent’s needs and providing information to the parent/guardian regarding their rights in determining the appropriate education/vocational setting for their child/adolescent. The child/adolescent should have everything that is necessary to be successful in an educational and/or vocational environment, including access to the family’s primary language for all meetings. TCM assists the parent/guardian in accessing educational and/or vocational advocacy and obtaining the appropriate education and/or vocational training for the child/adolescent and offers support in conflicts between the school and parent/guardian concerning the child/adolescent’s needs and services to be provided.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.
3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

**CHILDREN AND YOUTH SYSTEM INVOLVEMENT**

TCM may assist family in working with CYS and meeting CYS requirements for the parent/guardian or care giver/natural support and their child/adolescent with serious emotional disturbances. TCM assists the family in responding to the CYS family services plan. TCM may be needed to assure collaboration between the Children and Youth and Mental Health systems and a need for collaboration among multiple providers from these two systems. TCM may also participate in court processes for the family and the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

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N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Children and Youth System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and
healthy environment and assure child’s/adolescent’s participation in mental health services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child’s/adolescent’s participation in mental health services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child’s/adolescent’s participation in mental health services.

**JUVENILE JUSTICE/CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

A child or adolescent with a serious emotional disturbance who demonstrates delinquent behavior and/or is not compliant with probation and mental health service needs may require TCM support in addition to probation services. TCM uses his/her ongoing relationship with the child/adolescent and family to encourage compliance with the probation plan and participation in mental health services. TCM may be needed to assure collaboration between the Juvenile Justice/Criminal Justice and Mental Health systems. The TCM may also participate in court processes with family/juvenile.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Juvenile Justice/Criminal Justice System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.
1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.

**PARENT/GUARDIAN AND/OR OTHER FAMILY MEMBERS WITH SIGNIFICANT FAMILY NEEDS**

Other members of the family may have individual needs that have a serious impact on the child/adolescent’s ability to function at home and in the community. Other family members may have chronic mental illness, serious emotional disturbances, substance abuse problems, and/or physical illness that combine to compromise caretaker availability to the child. TCM provides culturally consistent and language appropriate service to the child/adolescent and family, assuring access and participation in services, including mental health services.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.
1= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a minimal level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

3= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a moderate level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

5= Other family members may have a mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a significant level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

**DRUG AND ALCOHOL SYSTEM INVOLVEMENT**

TCM assists family in obtaining drug and alcohol treatment for a child/adolescent with serious emotional disturbances and co-occurring drug and alcohol problems and encouraging child/adolescent to accept and comply with these services. The TCM supports the child’s/adolescent’s participation in all phases of treatment, including aftercare. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.*
N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Drug and Alcohol System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child’s/adolescent’s participation in drug and alcohol services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.

**MENTAL RETARDATION SYSTEM INVOLVEMENT**

TCM assists the family in obtaining and maintaining participation in mental retardation services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of mental retardation. The TCM supports the child’s/adolescent’s and parent’s/guardian’s participation in all phases of mental retardation services. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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Appendix T
Part B (4)

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Mental Retardation System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in mental retardation services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child’s/adolescent’s participation in mental retardation services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in mental retardation services.

**PHYSICAL HEALTH SYSTEM INVOLVEMENT**

TCM assists family and child/adolescent with a serious emotional disturbance in attending to significant physical/medical needs by helping parent/guardian to access medical care, and to develop confidence in working with physical health care providers. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.*

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

**CHILD/ADOLESCENT AT RISK OF OUT-OF-HOME PLACEMENT**

The risk that a child/adolescent with a serious emotional disturbance will require an out-of-home placement may be reduced significantly through TCM services which assist parent/guardian in accessing needed child serving systems. TCM assistance may include information sharing with parent/guardian, advocacy with mental health service providers and other systems and support in working with multiple service providers. Every effort should be made to consider the child’s ethnicity, culture and religious background in any out-of-home placement. TCMs may need to provide assistance in the provision of cultural competence supports for children (e.g., grooming, leisure activities, etc.).

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*
Appendix T
Part B (4)

Needs minimal assistance in this area  Needs moderate assistance in this area  Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at low risk of out-of-home placement.

3= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at moderate risk of out-of-home placement.

5= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at high risk of out-of-home placement.

**CURRENTLY IN RTF, OTHER OUT-OF-HOME PLACEMENTS OR INPATIENT**

Child/adolescent with a serious emotional disturbance is currently or has been receiving services in an RTF, other out-of-home placement or inpatient setting. The child/adolescent has been discharged within the past 30 days or discharge is anticipated within thirty 30 days. The child/adolescent may have been discharged for more than 30 days, however, TCM services are needed to assist with the discharge plan.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a minimal level of TCM service.

3= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a moderate level of TCM service.

5= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a significant level of TCM service.
TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - CHILD/ADOLESCENT

Agency

County

CHILDA/DOLESCENT INFORMATION:

Name :

(Last)                    (First)                       (MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth:             /        /

(MM)/(DD)/(YYYY)

Social Security Number:                  -         -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual’s need for the various levels of case management services. Please complete this form utilizing the individual’s behavior and situation during the last ninety days as a basis for scoring each indicator. Please note that the decision for level of need in each of the areas must be determined in collaboration with family and/or guardian, or care giver/natural supports and child/adolescent. Please see the Scoring Sheet for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.
ENVIRONMENTAL MATRIX CHILD/ADOLESCENT SCORING SHEET

CHILD/ADOLESCENT
NAME:______________________________________________________________________________

ID#(SOCIAL SECURITY/CIS/BSU):______________________________________________________

SCORES:

1. Accessing Mental Health Services ______________________
2. Informal Support Network Building ______________________
3. Education ______________________
4. Children and Youth System Involvement ______________________
5. Juvenile Justice System Involvement ______________________
6. Parent/Guardian and/or Other Family Members
   With Significant Needs ______________________
7. Drug and Alcohol System Involvement ______________________
8. Mental Retardation System Involvement ______________________
9. Physical Health System Involvement ______________________
10a. At Risk of Out-of-Home Placement ______________________

Or

10b. Currently in RTF, Other Out-of-Home Placements
     or Inpatient ______________________

SUBTOTAL ______________________

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ BY ALL
APPLICABLE ASSESSMENT AREAS (AREAS SCORED “N/A” ARE NOT
USED IN DETERMINING OVERALL SCORE)

OTHER FACTORS/ISSUES AFFECTING SCORE:


Commonwealth of Pennsylvania
HealthChoices Behavioral Health
TCM Child & Adolescent, Appendix T (Part B(4))
Program Standards and Requirements - Primary Contractor – County
ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT

TCM SERVICE SCORING GRID

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<td>4.0 – 5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended)</td>
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<td>1.5 – 3.9</td>
<td>RC</td>
<td>At least 1 contact every 30 days (Face to Face)</td>
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<td>0.0 - 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
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*professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE: ____________________________

CONSUMER (if age appropriate): ____________________________  DATE: ____________________________

PARENT/GUARDIAN: ____________________________  DATE: ____________________________

PERSON COMPLETING THE FORM: ____________________________  DATE: ____________________________

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE: ____________________________

REVIEWER: ____________________________  DATE: ____________________________
PENNSYLVANIA’S
CLIENT PLACEMENT CRITERIA
FOR ADULTS

Second Edition
January 1999

Tom Ridge
Governor
Commonwealth of Pennsylvania
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   1) Description of service level  

   2) Placement criteria for this level  

      a) Admission criteria  

      b) Continued Stay criteria  

      c) Discharge/Referral criteria  

E) Level 3A – Medically Monitored Inpatient Detox  

   1) Description of service level  

   2) Placement criteria for this level  

      a) Admission criteria  

      b) Continued Stay criteria  

      c) Discharge/Referral criteria  

F) Level 3B – Medically Monitored Short Term Residential  

   1) Description of service level  

   2) Placement criteria for this level  

      a) Admission criteria
b) Continued Stay criteria

c) Discharge/Referral criteria

G) Level 3C – Medically Monitored Long Term Residential

1) Description of service level

2) Placement criteria for this level

   a) Admission criteria

   b) Continued Stay criteria

   c) Discharge/Referral criteria

H) Level 4A – Medically Managed Inpatient Detox

1) Description of service level

2) Placement criteria for this level

   a) Admission criteria

   b) Continued Stay criteria

   c) Discharge/Referral criteria

I) Level 4B – Medically Managed Inpatient Residential

1) Description of service level

2) Placement criteria for this level

   a) Admission criteria

   b) Continued Stay criteria

   c) Discharge/Referral criteria
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Introduction:

Pennsylvania Client Placement Criteria for Adults

The Pennsylvania Client Placement Criteria for Adults (PCPC) are a set of guidelines designed to provide clinicians with a basis for determining the most appropriate care for clients with drug and alcohol problems. These guidelines, which have been modified to fit the specific needs and circumstances of the state of Pennsylvania, include admission, continued stay, and discharge and referral criteria. They have been formulated to promote a broad continuum of care which places clients in the least intrusive and medically safest setting, while providing the best opportunity to efficiently utilize health care resources. The PCPC were developed through a comprehensive process initiated by the Pennsylvania Bureau of Drug and Alcohol Programs (BDAP, formerly ODAP).

In 1993, BDAP began a comprehensive program to determine how to best ensure the most appropriate care for clients experiencing problems associated with the use of alcohol and other drugs. This program, involving treatment providers, researchers, Single County Authorities, managed care organizations, and policy makers across the state of Pennsylvania, was begun in response to a series of developments in drug and alcohol legislation. In 1988, legislation was passed that required BDAP to develop criteria “governing the type, level, and length of care or treatment” of drug and alcohol clients funded under Act 152. Soon after, in 1990, the Legislative Budget and Finance Committee recommended that the Department develop “performance standards,” new “case management regulations,” and “a comprehensive standard assessment instrument to identify the most appropriate care.” The Governor’s Drug Policy Council, relating to the oversight of Health Maintenance Organizations, made similar recommendations in 1991.

BDAP began this initiative by establishing a Treatment Task Force that met for the first time in February 1993. This Task Force had four immediate objectives:

1) To recommend criteria for client assessment and placement;
2) To recommend a list of acceptable assessment and placement instruments for statewide use;
3) To recommend standards and guidelines that could be used in monitoring drug and alcohol managed care plans; and
4) To recommend draft review criteria and procedures that could be used in analyzing, reviewing, and recommending the use of additional placement and assessment instruments.

The criteria that the Task Force sought to develop were not expected to tell professionals how to treat their clients. Rather, they were supposed to be simple, minimum standards used to inform the decision as to whether a drug and alcohol client should have inpatient care, non-hospital rehabilitation, or outpatient care of some sort. It was expected that...
these guidelines would go a long way in promoting a broad continuum of care that placed clients in a setting that would be the least intrusive, while providing the best opportunity to efficiently utilize health care resources.

In the 1980’s, the National Association of Addiction Treatment Providers (NAATP) and the American Society of Addiction Medicine (ASAM) worked to refine the existing client placement criteria. They hoped that the resulting criteria would more effectively discriminate between the needs for different types of care, enhance the guidelines for assessing the need for continued care at a given level of treatment, and improve the matching of client needs to appropriate treatment resources. They identified and described four levels of treatment, differentiated by degrees of direct medical management, structure, and treatment intensity. The NAATP/ASAM Patient Placement Criteria were superseded in June of 1991 by the ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. This document was used as one of the key foundations of the ODAP project, although it needed to be modified to fit the specific needs and circumstances of the state of Pennsylvania. ODAP soon received permission from ASAM to make these modifications.

Twelve focus groups were established to assist in the development of the Pennsylvania criteria: Outpatient care, Intensive Outpatient care, Partial Hospitalization, Short Term Rehabilitation (medically managed and medically monitored), Detoxification (medically managed and medically monitored), Methadone Treatment, treatment in Halfway House settings, Long Term Rehabilitation, Psychiatric Issues, Issues of Women with Children, Cultural Issues, and Alternative Lifestyle Issues. These groups were charged with the responsibility of identifying specific criteria to supplement the ASAM Patient Placement Criteria for each particular area, and to develop materials specific to the client characteristics which indicate that the individual is appropriate for the care modality being addressed. They assumed a full continuum of care for each client, a previous diagnosis of Psychoactive Substance Use Disorder for the client, as defined by the current DSM, and an acceptance of the ASAM criteria on the part of each focus group for their particular level.

The focus groups were expected to develop clinical assessment guidelines in such areas as the level of progression within recovery expected for a client upon entering a particular service, the client need identifiers which indicate the appropriateness of a specified service, and the level of functioning within recovery which is reached when it is appropriate for the client to be transferred to the next level of service. The focus groups were also asked to isolate Admission Criteria, Continued Stay Criteria, and Discharge Criteria.
The following criteria are the work of those focus groups. They are ordered from least to most intensive modalities, and include general guidelines for: Outpatient care, Intensive Outpatient care, Partial Hospitalization, Short term Rehabilitation (medically managed and medically monitored), treatment in Halfway House settings, Long term Rehabilitation, and Detoxification (medically managed and medically monitored). In addition, specific areas of clinical consideration are addressed, including patients in pharmacotherapy (e.g. methadone), psychiatric comorbidity, and issues concerning gender, culture, and alternative lifestyles.
The Pennsylvania Department of Health and the Bureau of Drug and Alcohol Programs (BDAP) would like to thank all those individuals whose hard work has contributed to the development and refinement of the Pennsylvania Client Placement Criteria (PCPC) for Adults. Without tireless efforts and countless hours, this vitally important project would likely have never been completed.

We applaud the work of the Clinical Standards Committee, which was charged to support the implementation and further development of the PCPC, and to address additional clinical and systemic issues relevant to substance abuse treatment in the Commonwealth of Pennsylvania. The following are recognized for their work on this Committee:

Louis Baxter, Sr., M.D., FASAM, Hospital Association of Pennsylvania (HAP)
Kim Bowman, Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA)
Jack DeWitt, Pennsylvania Community Providers Association
Mike Harle, Drug and Alcohol Service Providers of Pennsylvania (DASPOP)
Terrence McSherry, Pennsylvania Alliance
Janice Pringle, Ph.D., St. Francis Medical Center
Mark Besden, CAC, Halfway House Association
Robert L. Primrose, CAAP, Pennsylvania Bureau of Drug and Alcohol Programs

The Committee agreed to form subcommittees addressing issues such as, but not limited to, ambulatory detoxification, adolescent issues, technical review and revision, and assessment. BDAP would like to thank all those who have participated on these various subcommittees for their dedication and commitment. In particular, BDAP would also like to recognize the work of the Technical Review Subcommittee, whose initiatives and effort made the revision of the PCPC a reality. This Subcommittee was given an assortment of tasks including: reviewing the criteria for editorial and content issues, making recommendations for changes, developing a system for eliciting comments from the field, reviewing the mechanisms used in training and communicating with clinicians in the use of the PCPC, reviewing and recommending systems for administering the PCPC and recording the results of evaluations in client charts, and developing a mechanism for systematizing communications with other entities involved in PCPC research and training.

Finally, BDAP would like to recognize and give special thanks to its Division of Treatment for their tireless efforts and support, and to Nicholas Emptage and Cele Fichter of St. Francis Medical Center for their work in reformatting and rewriting the Pennsylvania Client Placement Criteria manual in its present form.
How to Use the Criteria

The Clinical Decision-Making Process: Gathering, Interpreting, and Applying Information

Gathering Information

A comprehensive clinical assessment is vital to the placement process, and must be conducted by a qualified professional prior to applying the PCPC for level of care determination. Because substance use disorders are biopsychosocial in nature, assessments must be comprehensive and multidimensional to determine the level of care and service needs of the client.

Assessing the client for any special needs is also an important part of this process. The Department of Health recognizes that clients who come from specific backgrounds, or whose lives are affected by special circumstances, may require placement in a program tailored to meet their specific needs. Appendix A of the Pennsylvania Client Placement Criteria includes sample assessment questions and narratives describing such programs for the following populations: clients currently engaged in pharmacotherapy, clients with coexisting mental illnesses, women, women with children, clients from ethnic minorities, and gays and lesbians.

Interpreting Information – The Dimensional Approach

Once assessment information is gathered, it can be related to each of the six dimensions specified in the PCPC. Individuals who have been diagnosed as having a substance use disorder are very often suffering with other conditions or problems at the same time. These additional difficulties can have a significant impact on the client’s understanding and confrontation of his or her presenting problem and on the fulfillment of his or her long-term treatment goals. Client information is interpreted and related to the PCPC so that a clinical determination can be made according to dimensional specifications (see the dimensional matrix under each type of service for detailed specifications). While the dimensions are comprehensive in taking into account all of the factors involved in a client’s addiction, the goal of each dimension is to capture a particular facet of the client’s problem and gauge the severity or degree to which that facet contributes to the overall disorder.

The Pennsylvania Client Placement Criteria guides placement determinations based on severity and level of functioning in each of the following dimensions:
Acute Intoxication and Withdrawal – This dimension addresses the severity of the client’s presenting substance use disorder. The interviewer attempts to assess the severity of the client’s addiction and the degree of impairment in everyday functioning. Of particular concern is the risk of severe withdrawal syndrome. A client who is experiencing symptoms of withdrawal (or who is at great risk of doing so) may require treatment in an intensive type of service.

Biomedical Conditions and Complications – This dimension investigates the client’s overall physiological condition in order to determine whether there are any medical problems or concerns. If a client is suffering from a medical problem that is complicated by the use of alcohol or drugs, or he or she has a health problem of such severity that medical care is immediately necessary, then the inclusion of medical management in the treatment setting becomes critically important.

Emotional/Behavioral Conditions and Complications – This dimension addresses the client’s mental status, in terms of the effects of any emotional or behavioral problems on the presenting substance use disorder. The client is evaluated in terms of his or her emotional stability, and the interviewer attempts to assess the degree to which the client could present a danger to self or others. The goal of this dimension is to identify any psychological disorders which could complicate drug and alcohol treatment, and which may need to be treated concurrently. This dimension also identifies any unpredictable or self-defeating behaviors in response to emotional or environmental stressors.

Treatment Acceptance/Resistance – This dimension examines the client’s attitude towards treatment. The degree to which the client understands the nature and consequences of his or her addiction, as well as his or her motivation to engage in recovery, are vital considerations to be made when deciding upon an appropriate setting for treatment.

Relapse Potential – This dimension’s focus is the client’s ability to maintain abstinence from alcohol and other drugs. It examines how the client deals with triggers and cravings, and attempts to assess what changes in behavior are needed for him or her to maintain abstinence. Like the treatment acceptance dimension, this is a critical gauge of the degree of structure the client needs in his or her treatment program.

Recovery Environment – This dimension evaluates the client’s social and living environment in terms of how it promotes or denigrates the client’s recovery efforts. Its main concern is whether or not the client’s peers, family, and/or significant others are supportive of his or her recovery, either directly or indirectly. Severe conditions can require relief from the social environment in a structured setting, and information about the client’s coping patterns can be valuable in developing his or her treatment plan.
Applying Information (How to Make a Level of Care Determination or Placement Decision):

Once the client has been properly assessed, and he or she meets each dimensional specification for a particular level of care, the PCPC provides for an overall level of care determination based on all the dimensions. This is often referred to as dimensional scoring.

Information obtained from a comprehensive assessment is interpreted according to dimensional severity (using the PCPC dimensional matrix) in order to determine the most appropriate level of care and type of service. Each level of care, from outpatient to medically managed residential, has its own dimensional specifications. For example, for a Level 1A (Outpatient) determination, the client must meet the dimensional specifications for outpatient care in dimensions 1, 2, 3, 4, 5, and 6 (see the Criteria Overview, page 11, or the dimensional matrix, pages 17 to 24, for additional level of care specifications).

The PCPC includes 4 levels of care and 9 types of service:

- **Level 1**
  - A Outpatient
  - B Intensive Outpatient

- **Level 2**
  - A Partial Hospitalization
  - B Halfway House

- **Level 3**
  - A Medically Monitored Detox
  - B Medically Monitored Short-Term Residential
  - C Medically Monitored Long-Term Residential

- **Level 4**
  - A Medically Managed Inpatient Detox
  - B Medically Managed Inpatient Residential

Admission, Continued Stay, Discharge/Referral Criteria:

As the full clinical picture emerges through continued evaluation, placement decisions and lengths of stay may need to be reconsidered. Admission, continued stay, and discharge/referral criteria should therefore be utilized at every type of service throughout

* Pennsylvania licensing requirements and descriptions of services can be found in each level of care section.
the continuum of care. In this way, the client receives alcohol and other drug treatment services at the most appropriate level of care (LOC) until he or she has developed coping strategies sufficient to be able to support a self-directed recovery program, and no longer meets the admission criteria for any level of care.

**When to use continued stay criteria:**

Continued stay criteria are used to review and determine the clinical necessity of a client’s status in a particular level of care and type of service. Use of continued stay criteria ultimately determines the appropriate length of stay (until admission criteria are met for another LOC or the client is discharged from the continuum).

The treatment funding source has discretion as to when to utilize continued stay criteria for concurrent review. However, the Bureau of Drug and Alcohol Programs (BDAP) provides the following **recommended** time frames:

<table>
<thead>
<tr>
<th>Service</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>every 30 days to 120 days</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>every 30 days to 120 days</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>every 30 days to 120 days</td>
</tr>
<tr>
<td>Halfway House</td>
<td>every 30 days</td>
</tr>
<tr>
<td>Medically Monitored Detox</td>
<td>every 3 days</td>
</tr>
<tr>
<td>Medically Monitored Residential, Short-Term</td>
<td>every 7 days</td>
</tr>
<tr>
<td>Medically Monitored Residential, Long-Term</td>
<td>every 30 days</td>
</tr>
<tr>
<td>Medically Managed Inpatient Detox</td>
<td>every day</td>
</tr>
<tr>
<td>Medically Managed Residential</td>
<td>every 7 days</td>
</tr>
</tbody>
</table>

Continued stay criteria should also be used whenever deemed clinically appropriate by the treatment provider.

**Using the discharge criteria if a client leaves against staff/medical advice:**

In the case of a client who leaves a particular level of care against staff advice and without giving notice, the discharge/referral criteria may not be applicable. Utilization of the criteria should be evidenced up to that point. In the case of a client discharged for lack of compliance, referral criteria should be completed with documentation detailing the client’s failure to comply.

**A note on documentation and clinical justification for services:**

The client record is designed to:
1. Provide clinical justification for placement by matching addiction severity with the appropriate level of care;
2. Objectively document the need for specific interventions and support services in key biopsychosocial domains; and

The record should provide a summation of a client’s condition and progress, specifically, accurately, objectively, and in standardized clinical terms. Jargon and personal opinion have no place in a professional record.

When documenting clinical justification for a prescribed level of care, it is important that client-specific information be recorded and related with the PCPC in each of the six dimensions. Verbatim quotes from the PCPC matrix are insufficient without supporting individualized data elements. Consider the following examples:

1. In Dimension 2, Level 4A, Item G, the PCPC reads:
   Chemical use gravely complicating or exacerbating previously diagnosed medical condition.

   The clinical record should include client-specific information, such as:
   Client’s daily alcohol use exacerbates liver inflammation due to known hepatitis C infection, which places client at risk of developing cirrhosis;

2. In Dimension 4:
   Client does not accept or understand severity of problems related to substance use.

   The clinical record should include:
   Despite client’s awareness of his high-risk status for developing cirrhosis of the liver, along with continued daily health problems, the client does not connect the serious role of alcohol use to his health problems.

Examples 1 and 2 provide clear and specific reasons for recommending a level of care, within the framework provided by the PCPC Matrix Item in the first example. Every relevant individual clinical presentation can be documented in a similar way, providing core information, stated succinctly, which can then be used in both treatment planning and clinical application.

All interactions with a client should be documented in an objective, professional manner, including those situations in which a client refuses a recommended service. Mitigating circumstances compelling a client to make choices which conflict with clinical recommendations should be included in the chart narrative.

In summary, a client chart is a written record of the history of a professional relationship.

Good clinical documentation is an integral part of providing quality client service.
The following process illustrates the use of admission, continued stay, and discharge/referral criteria:

**STEP ONE:** The client is assessed by a drug and alcohol professional. The Pennsylvania Client Placement Criteria admission criteria are used to guide the assessor in placing the client in an appropriate level of care and type of service. The assessor forwards the PCPC summary sheet to the authorizing agency and admitting provider (if applicable*).

**STEP TWO:** Continued stay criteria are utilized to determine whether the client should stay in the current level of care and type of service. The PCPC summary sheet should be forwarded to the authorizing agency. If the client does not meet continued stay criteria, proceed to Step Three.

**STEP THREE:** The discharge/referral criteria are used. If discharge from the system is appropriate for the client, the PCPC discharge summary sheet should be forwarded to the authorizing agency and no further. If the client meets referral criteria (including admission criteria for another type of service), the PCPC summary sheet should be forwarded to the authorizing agency and admitting treatment provider (if applicable) before continuing to Step Four.

**STEP FOUR:** A referral is made to an appropriate provider. The admitting provider then proceeds with the clinical biopsychosocial assessment, and forwards the PCPC summary sheet to the authorizing agency.

* The appropriate signed client consent to release information must proceed forwarding the PCPC Summary Sheet and any other client information.
### Admission Criteria Overview*

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 1A – Outpatient</th>
<th>Level 1B – Intensive Outpatient</th>
<th>Level 2A – Partial Hospitalization</th>
<th>Level 2B – Halfway House</th>
<th>Level 3A – Medically Monitored Inpatient Detox</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Intoxication or Withdrawal</td>
<td>Minimal to no risk of withdrawal</td>
<td>Minimal to no risk of withdrawal</td>
<td>Minimal risk of severe withdrawal</td>
<td>Minimal to no risk of withdrawal</td>
<td>High risk of severe withdrawal, daily use with physical dependence but without psychiatric or medical disorder requiring medical management</td>
</tr>
<tr>
<td>Biomedical Conditions and Complications</td>
<td>Stable enough to permit participation</td>
<td>Not severe enough to warrant inpatient, but may distract from recovery efforts.</td>
<td>Not severe enough to warrant twenty-four-hour observation; relapse could severely exacerbate conditions</td>
<td>Conditions do not interfere with treatment and do not require monitoring outside of this level; OR relapse would severely aggravate existing condition</td>
<td>Medical condition severely endangered by continued use, requires close medical monitoring but not intensive care</td>
</tr>
<tr>
<td>Emotional/Behavioral Conditions and Complications</td>
<td>Non-serious, transient emotional disturbances; mental status allows full participation</td>
<td>Able to maintain behavioral stability between contacts, symptoms do not obstruct participation</td>
<td>Inability to maintain behavioral stability over seventy-two-hour period; OR mild risk of dangerous behavior; OR history of dangerous behavior</td>
<td>Conditions do not interfere with treatment and disorders may be treated concurrently; at least one serious emotional/behavioral problem is present</td>
<td>Psychiatric symptoms interfere with recovery, moderate risk of dangerous behaviors, impairment requires twenty-four-hour setting; self-destructive behavior related to intoxication</td>
</tr>
<tr>
<td>Treatment Acceptance/Resistance</td>
<td>Willing and cooperative; requires only monitoring and motivation rather than structure</td>
<td>Willing and cooperative; requires only monitoring and motivation rather than structure</td>
<td>Structured milieu required due to denial or resistance, but not so severe as to require residential setting</td>
<td>Cooperative and accepts need for twenty-four-hour structured setting</td>
<td>N/A</td>
</tr>
<tr>
<td>Relapse Potential</td>
<td>Able to maintain abstinence with support and counseling</td>
<td>Needs support and counseling; difficulty postponing immediate gratification</td>
<td>Likely to continue use without monitoring and intensive support; OR difficulty maintaining abstinence despite engagement in treatment</td>
<td>Unaware of relapse triggers, impulsivity, would likely relapse without structured setting</td>
<td>N/A</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>Supportive living environment or environment in which stressors can be managed so that abstinence can be maintained</td>
<td>Not optimal, but has supportive living environment or motivation to establish one; available supports willing to help facilitate recovery</td>
<td>Exposure to usual daily activities makes recovery unlikely; OR inadequate support for recovery from significant others; OR estrangement from potential support in living environment</td>
<td>Lack of supportive persons in living environment; significant stressors; OR logistic barriers to treatment at less intensive level of care</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Admission Criteria

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 3B – Medically Monitored Short Term Residential</th>
<th>Level 3C – Medically Monitored Long Term Residential</th>
<th>Level 4A – Medically Managed Inpatient Detox</th>
<th>Level 4B – Medically Managed Inpatient Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Intoxication or Withdrawal</strong></td>
<td>Minimal to no risk of severe withdrawal</td>
<td>Minimal to no risk of withdrawal with ongoing post acute withdrawal symptoms</td>
<td>Risk of severe withdrawal, with co-occurring psychiatric or medical disorder requiring medical management; OR overdose requiring medical management; OR only available setting that meets client’s management needs</td>
<td>Minimal to no risk of withdrawal</td>
</tr>
<tr>
<td><strong>Biomedical Conditions and Complications</strong></td>
<td>Continued AOD use places client in possible danger of serious damage to physical health</td>
<td>Continued AOD use places client in danger of serious damage to physical health</td>
<td>Complications of addiction require daily medical management; OR medical problem require diagnosis and treatment; OR recurrent seizures</td>
<td>Imminent danger of serious physical health problems requiring intensive medical management</td>
</tr>
<tr>
<td><strong>Emotional/Behavioral Conditions and Complications</strong></td>
<td>Psychiatric symptoms interfere with recovery; moderate risk of dangerous behaviors; impairment requires twenty-four-hour setting; self-destructive behaviors related to intoxication</td>
<td>Two of: disordered living skills, disordered social adaptation, disordered self-adaptiveness, disordered psychological status</td>
<td>Emotional/behavioral complications of addiction require daily medical management; OR risk of dangerous behavior; OR substance use would have severe mental health consequences</td>
<td>Two of: psychiatric complications of addiction; concurrent psychiatric illness; dangerous behaviors; mental confusion or other impairment of thought process</td>
</tr>
<tr>
<td><strong>Treatment Acceptance/Resistance</strong></td>
<td>Twenty-four-hour intensive program needed to help client understand consequences and severity of addiction</td>
<td>Twenty-four-hour intensive program needed to help client understand consequences and severity of addiction</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Relapse Potential</strong></td>
<td>Inability to establish recovery despite previous treatment in less intensive settings; unable to control use in face of available substances in environment</td>
<td>Inability to establish recovery despite previous treatment in less intensive settings; unable to control use in face of available substances in environment</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Recovery Environment</strong></td>
<td>Social elements unsupportive or highly stressful; coping skills inadequate to conditions</td>
<td>Social elements unsupportive or highly stressful; coping skills inadequate to conditions; OR anti-social lifestyle</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* This section is intended to serve as a general overview ONLY; for accurate application of the criteria, one must use the detailed dimensional and scoring specifications found in the descriptive narratives for each level.
### Continued Stay Criteria Overview*

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 1A – Outpatient</th>
<th>Level 1B – Intensive Outpatient</th>
<th>Level 2A – Partial Hospitalization</th>
<th>Level 2B – Halfway House</th>
<th>Level 3A – Medically Monitored Inpatient Detox</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Intoxication or Withdrawal</td>
<td>Post-acute withdrawal symptoms, occasional limited lapses may occur</td>
<td>Post-acute withdrawal symptoms, occasional limited lapses may occur</td>
<td>Post-acute withdrawal symptoms, occasional limited lapses may occur</td>
<td>Post-acute withdrawal symptoms, occasional limited lapses may occur</td>
<td>Persistent withdrawal symptoms or cognitive impairment; this LOC is needed to achieve stability</td>
</tr>
<tr>
<td>Biomedical Conditions and Complications</td>
<td>Any medical conditions do not prevent progress in treatment</td>
<td>Any medical conditions do not prevent progress in treatment</td>
<td>Medical conditions may potentially distract from recovery efforts and may require monitoring which can be provided at this level</td>
<td>Client making progress and medical status can be managed at this LOC by community resources</td>
<td>Any medical problems can be adequately managed at this level</td>
</tr>
<tr>
<td>Emotional/Behavioral Conditions and Complications</td>
<td>Ongoing emotional disturbances not so severe as to prevent progress</td>
<td>Emotional problems may be distracting, but there are indications that client is responding to treatment</td>
<td>Emotional problems may be distracting, but there are indications that client is responding to treatment</td>
<td>Improving behavioral stability, stress adaptation, decision-making, and social functioning which requires reinforcement provided by this type of service</td>
<td>Emotional/behavioral status improving, but continuing treatment in this type of service is required</td>
</tr>
<tr>
<td>Treatment Acceptance/Resistance</td>
<td>Understanding of addiction insufficient to maintain self-directed plan of recovery</td>
<td>Beginning to recognize responsibility for illness, but requires intense motivation</td>
<td>Beginning to accept responsibility for recovery, but needs intensive motivation and support to maintain progress</td>
<td>Recognizes severity of problem, but has not assumed responsibility for behavioral change</td>
<td>Recognizes severity of problem but has little understanding of personal role in its development</td>
</tr>
<tr>
<td>Relapse Potential</td>
<td>Continuing mental preoccupation with use, and need to enhance recovery skills</td>
<td>Beginning to recognize relapse potential, but has not fully developed or consistently applied behavioral changes</td>
<td>Recognizes relapse potential, but has not yet fully developed or applied behavioral changes; requires structured program to do so</td>
<td>Recognizes relapse triggers and dysfunctional behavior w/o skill needed to arrest this behavior and apply adequate coping skills to maintain abstinence</td>
<td>N/A</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>Sufficient skills to cope with any non-supportive elements in living environment, but not yet able to maintain self-directed plan of recovery</td>
<td>Client making progress in learning to cope with environmental obstacles to recovery</td>
<td>Has not yet developed sufficient coping or socialization skills to establish stability in living environment without this level of intense support and treatment</td>
<td>Has not developed adequate coping skills, socialization skills, or social support to deal with living environment without this type of service</td>
<td>Living environment makes abstinence unlikely</td>
</tr>
</tbody>
</table>
# Continued Stay Criteria

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 3B – Medically Monitored Short Term Residential</th>
<th>Level 3C – Medically Monitored Long Term Residential</th>
<th>Level 4A – Medically Managed Inpatient Detox</th>
<th>Level 4B – Medically Managed Inpatient Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Intoxication or Withdrawal</td>
<td>Protracted withdrawal symptoms present obstacles to recovery but do not interfere with treatment at this level; OR limited lapses may have occurred</td>
<td>Protracted withdrawal symptoms present obstacles to recovery but do not interfere with treatment at this level; OR limited lapses may occur more prominently and persistently than those cited for 3B</td>
<td>Persistence of acute withdrawal</td>
<td>Significant post-withdrawal symptoms persist which may be obstacles to engagement</td>
</tr>
<tr>
<td>Biomedical Conditions and Complications</td>
<td>Medical problems are not resolved but client making progress in recognition of impact of use on medical condition</td>
<td>Medical problems are not resolved but client is making progress in recognition of impact of AOD use on medical condition</td>
<td>Biomedical status not sufficiently altered to allow management in less intensive setting</td>
<td>Improvement in medical status not sufficient to allow management at less intensive type of service</td>
</tr>
<tr>
<td>Emotional/Behavioral Conditions and Complications</td>
<td>Emotional/behavioral problems are improving but require treatment in this type of service</td>
<td>Demonstrating signs of progress in addressing disordered living skills, social adaptation, self-adaptation, and psychological status, but needs continued structure to maintain progress</td>
<td>Emotional/behavioral status not sufficiently altered to allow management in less intensive setting; OR waiting transfer to acute psychiatric care</td>
<td>Improvement in mental status not sufficient to allow management at less intensive type of service</td>
</tr>
<tr>
<td>Treatment Acceptance/Resistance</td>
<td>Beginning to recognize severity of problem and understand personal role in its existence</td>
<td>Beginning to recognize severity of problem and understand personal role in its existence, or recognizes and understands problems but has not taken responsibility for recovery</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Relapse Potential</td>
<td>Does not demonstrate skills necessary to arrest dysfunctional behaviors but shows progress</td>
<td>Does not demonstrate skills necessary to arrest dysfunctional behaviors, but shows progress despite minimal understanding of personal role in relapse</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>Living environment still poses a danger and coping skills have not improved sufficiently to manage dangers or stressors in the environment</td>
<td>Living environment still poses a danger and coping skills have not improved sufficiently to manage dangers or stressors in the environment OR anti-social lifestyle</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* This section is intended to serve as a general overview ONLY; for accurate application of the criteria, one must use the detailed dimensional and scoring specifications found in the descriptive narratives for each level.
## Discharge/Referral Criteria Overview*

NOTE: The **Discharge Criteria** in all dimensions and at all levels indicate that clients do not meet continued stay criteria for this service or admission criteria for any other service.

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 1A – Outpatient</th>
<th>Level 1B – Intensive Outpatient</th>
<th>Level 2A – Partial Hospitalization</th>
<th>Level 2B – Halfway House</th>
<th>Level 3A – Medically Monitored Inpatient Detox</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Intoxication or Withdrawal</strong></td>
<td>D: No post-acute or protracted withdrawal; R: Meets admission criteria for another type of service</td>
<td>D: No post-acute or protracted withdrawal; R: Meets admission criteria for another type of service</td>
<td>D: No post-acute or protracted withdrawal; R: Meets admission criteria for another type of service</td>
<td>D: Minimal or no risk of withdrawal; R: AOD use; meets admission criteria for another type of service</td>
<td>D: N/A R: Client meets criteria for another level of care</td>
</tr>
<tr>
<td><strong>Biomedical Conditions and Complications</strong></td>
<td>D: Medically stable; R: Meets admission criteria for another type of service</td>
<td>D: Medical problems stable or manageable in outpatient setting; R: Meets admission criteria for another type of service</td>
<td>D: Medical condition can be managed in another setting intensity; R: Meets admission criteria for another type of service</td>
<td>D: Medical condition manageable using community resources; R: Meets admission criteria for another type of service</td>
<td>D: Medical condition has stabilized; R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td><strong>Emotional/Behavioral Conditions and Complications</strong></td>
<td>D: Stable; R: Emotional disturbances; meets admission criteria for another type of service</td>
<td>D: Emotionally and behaviorally stable; R: Emotional condition meets admission criteria for another type of service</td>
<td>D: Behaviorally stable between contacts, emotional distress does not interfere with treatment; R: Meets admission criteria for another type of service</td>
<td>D: Shows stable, regulated behavior; R: Meets criteria for another type of service</td>
<td>D: Emotional/behavioral condition no longer requires twenty-four-hour monitoring; R: Deteriorated; meets criteria for another type of service</td>
</tr>
<tr>
<td><strong>Treatment Acceptance/Resistance</strong></td>
<td>D: Ready to maintain self-directed recovery; R: Meets admission criteria for another type of service</td>
<td>D: Ready to maintain self-directed recovery; R: Meets admission criteria for another type of service</td>
<td>D: Progress in recognition and understanding of addiction and recovery; R: Lack of progress, meets admission criteria for another type of service</td>
<td>D: Capable of self-directed recovery, has ability to apply learning skills to maintain sobriety; R: Meets admission criteria for another type of service</td>
<td>D: Recognizes severity and personal role in problems, accepts need for continuing care; R: Meets criteria for another type of service</td>
</tr>
<tr>
<td><strong>Relapse Potential</strong></td>
<td>D: Client has integrated and internalized relapse prevention skills; R: Meets admission criteria for another type of service</td>
<td>D: Client has integrated and internalized relapse prevention skills; R: Meets admission criteria for another type of service</td>
<td>D: Developed (but not integrated) coping skills; R: Meets admission criteria for another type of service</td>
<td>D: Capable of managing recovery plan, has adequate relapse prevention skills; R: Meets admission criteria for another type of service</td>
<td>D: Capable of managing recovery plan, has adequate relapse prevention skills; R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td><strong>Recovery Environment</strong></td>
<td>D: Adequate function in current living environment to maintain self-directed recovery; R: Environment disrupts recovery process at this level; meets admission criteria for another type of service</td>
<td>D: Adequate function in current living environment to maintain self-directed recovery; R: Environment disrupts recovery process at this level; meets admission criteria for another type of service</td>
<td>D: Supports, stressors, and coping skills have improved; R: Deterioration, meets admission criteria for another type of service</td>
<td>D: Supports, stressors, and coping skills have improved; R: Deterioration, meets admission criteria for another type of service</td>
<td>D: Living environment or coping skills improved; R: Deterioration, meets admission criteria for another type of service</td>
</tr>
</tbody>
</table>
## Discharge/Referral Criteria

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Level 3B – Medically Monitored Short Term Residential</th>
<th>Level 3C – Medically Monitored Long Term Residential</th>
<th>Level 4A – Medically Managed Inpatient Detox</th>
<th>Level 4B – Medically Managed Inpatient Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Intoxication or Withdrawal</td>
<td>D: No post-acute or protracted withdrawal syndrome;</td>
<td>D: No post-acute or protracted withdrawal;</td>
<td>D: N/A</td>
<td>D: No post-acute or protracted withdrawal;</td>
</tr>
<tr>
<td></td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td>Biomedical Conditions and Complications</td>
<td>D: Medical condition stable enough for another type of service;</td>
<td>D: Medical condition stable enough to allow for another service;</td>
<td>D: Medical status no longer requires full-time management;</td>
<td>D: Stabilization of medical status;</td>
</tr>
<tr>
<td></td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Deterioration; meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td>Emotional/Behavioral Conditions and Complications</td>
<td>D: Emotional/behavioral condition no longer requires twenty-four-hour monitoring;</td>
<td>D: Emotional condition no longer requires twenty-four-hour monitoring;</td>
<td>D: Mental status stable, twenty-four-hour management not required;</td>
<td>D: Stabilization of mental status;</td>
</tr>
<tr>
<td></td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Deterioration; meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td>Treatment Acceptance/Resistance</td>
<td>D: Recognizes severity and personal role in problems;</td>
<td>D: Recognition and understanding of problem;</td>
<td>D: Recognition and understanding of problem;</td>
<td>D: Recognition and understanding of problem;</td>
</tr>
<tr>
<td></td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
</tr>
<tr>
<td>Relapse Potential</td>
<td>D: Capable of following recovery plan;</td>
<td>D: Capable of following recovery plan;</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>R: Meets admission criteria for another type of service</td>
<td>R: Meets admission criteria for another type of service</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>D: Living environment or coping skills improved;</td>
<td>D: Living environment or coping skills improved;</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>R: Deterioration; meets admission criteria for another type of service</td>
<td>R: Deterioration; meets admission criteria for another type of service</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* This section is intended to serve as a general overview ONLY; for accurate application of the criteria, one must use the detailed dimensional and scoring specifications found in the descriptive narratives for each level.
Level 1A
Outpatient

Description of Service Level

- Outpatient treatment is an organized, non-residential treatment service providing psychotherapy in which the client resides outside the facility. These services are usually provided in regularly scheduled treatment sessions for, at most, 5 hours per week.
- Outpatient treatment may be conducted at any Pennsylvania Department of Health licensed drug and alcohol facility as stipulated in 28 PA Code.
- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio is not to exceed 35:1.

Required Services and Support Systems include:

- Biopsychosocial Assessment
- Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 60 days
- Psychotherapy, including individual, group, and family (per clinical evaluation)
- Aftercare planning and follow-up

Recommended Services and Support Systems include:

- Occupational and vocational counseling
- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of shelter and other basic needs
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive levels of care, as clinically indicated
- Collaboration between the treatment team and various agencies for the coordinated provision of services

The Required Staff at an outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.
The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.
# Level 1A (Outpatient care)
## Admission Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
<th>Clients must meet Level 1A criteria for all six dimensions.</th>
</tr>
</thead>
</table>
| 1. **Acute Intoxication or Withdrawal** | Clients must meet all of the following:  
   A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:  
      1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol, with no medication; OR  
      2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR  
      3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention; AND  
   B. For clients with withdrawal symptoms no more severe than those noted in Section A, the client has, and responds positively to, emotional support and comfort as evidenced by:  
      1. Decreased emotional symptoms by the end of the initial interview session, AND  
      2. Home environment able to provide adequate support. |
| 2. **Biomedical Conditions and Complications** | Any of the client’s biomedical conditions, if present, are (or continue to be) sufficiently stable to permit participation in outpatient treatment. |
| 3. **Emotional/Behavioral Conditions and Complications** | Clients must meet all of the following:  
   A. The client’s anxiety, guilt, and/or depression, if present, appear to be related to chemical dependency problems rather than a coexisting psychiatric/emotional/behavioral condition. If they are related to such a condition, appropriate additional psychiatric services are provided concurrently.  
   B. The mental status of the client does not preclude his/her ability to:  
      1. Comprehend and understand the materials presented,  
      2. Participate in the treatment process, and  
      3. The client is assessed as not being at risk of harming self or others. |
| 4. **Treatment Acceptance/Resistance** | Clients must meet all of the following:  
   A. The client expresses willingness to cooperate and attend all scheduled activities, and;  
   B. The client may also admit that he/she has an alcohol/drug problem but requires monitoring and motivating strategies. However, the client does not need a structured milieu program. |
<p>| 5. <strong>Relapse Potential</strong> | The client is assessed as being able to maintain abstinence and recovery goals only with support and scheduled therapeutic contact to help to deal with issues such as, but not limited to, mental preoccupation with alcohol/drug use, craving, peer pressures, lifestyle, and attitudinal changes. |</p>
<table>
<thead>
<tr>
<th>6. Recovery Environment</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>A sufficiently supportive psychosocial environment makes outpatient treatment feasible (e.g. significant others who are in agreement with recovery efforts, supportive work or legal coercion, adequate transportation to the program, and support meeting locations and non-alcohol/drug centered work that are accessible and close to home environment);</td>
</tr>
<tr>
<td>B.</td>
<td>The client has demonstrated motivation and a willingness to obtain an ideal primary or social support system to assist with immediate sobriety, even though he/she does not presently have such a support system;</td>
</tr>
<tr>
<td>C.</td>
<td>Family/significant others are supportive, but client requires professional interventions to improve chances of treatment success and recovery (e.g. assistance in limit-setting and communication skills, and a decrease in rescuing behaviors, etc.).</td>
</tr>
</tbody>
</table>
## Dimensional Scoring Specifications

Clients must meet, at a minimum, ONE of the Level 1A criteria for Dimensions 3, 4, 5, or 6, and meet criteria no higher than Level 1A for the remaining dimensions.

### 1. Acute Intoxication or Withdrawal

Clients must meet ONE of the following:

- A. Acute symptoms of intoxication/withdrawal are absent in the client;
- B. Client presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety), which present obstacles to engaging in recovery and normal life functioning;
- C. The client reports a limited lapse of sobriety that can be addressed constructively.

### 2. Biomedical Conditions and Complications

Clients must meet ONE of the following:

- A. Any biomedical conditions, if present, continue to be sufficiently stable to permit continued participation in outpatient treatment;
- B. An intervening biomedical condition or event was serious enough to interrupt treatment but the client is again progressing in treatment.

### 3. Emotional/Behavioral Conditions and Complications

Clients must meet ONE of the following:

- A. The client is making progress in reducing anxiety, guilt, and/or depression, if present, yet these symptoms have not been resolved sufficiently for discharge;
- B. An intervening emotional/behavioral event or problem was serious enough to interrupt treatment, but with stabilization the client is again progressing in treatment.

### 4. Treatment Acceptance/Resistance

The client is continuing to work on treatment goals and objectives, yet he/she does not understand or accept his/her addiction sufficiently to maintain, as yet, a self-directed recovery plan.

### 5. Relapse Potential

Clients must meet ONE of the following:

- A. The client, while physically abstinent from alcohol/drug use, remains mentally preoccupied with such use to the extent that he/she is unable to adequately address primary relationships or social or work tasks. There are indications, however, that with continued treatment the client will effectively address these issues;
- B. The client, while physically abstinent from alcohol/drugs, and experiencing minimal craving for them, requires continued work on the development of an alternative lifestyle, thought patterns, and emotional responses. The client is making progress on these things.
<table>
<thead>
<tr>
<th>6. Recovery Environment</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>The social environment remains non-supportive or has deteriorated, but the client is making sufficient progress in learning social and other related coping skills to contend with the environment;</td>
</tr>
<tr>
<td>B.</td>
<td>The social system is supportive of recovery, but the client is not yet able to adhere to a self-directed recovery plan without substantial risk of reactivating substance use.</td>
</tr>
</tbody>
</table>
## Dimensional Scoring Specifications

Clients must meet Level 1A criteria for all dimensions.

### 1. Acute Intoxication or Withdrawal

**Discharge:**
Clients must meet all of the following:

A. The client is assessed as not being in intoxication or withdrawal;

B. The client does not manifest symptoms of protracted withdrawal syndrome; and

C. The client does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
The client is abusing alcohol or other drugs and meets admission criteria for a more intensive type of service.

### 2. Biomedical Conditions and Complications

**Discharge:**
The client’s biomedical problems, if any, have diminished or stabilized to the extent that they can be managed through outpatient appointments at his/her discretion, and he/she does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
There is a biomedical condition that is interfering with addiction treatment AND the client meets the admission criteria for a more intensive type of service.

### 3. Emotional/Behavioral Conditions and Complications

**Discharge:**
The client’s emotional or behavioral problems have diminished or stabilized to the extent that they can be managed through outpatient appointments at his/her discretion, and the client does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
Psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment AND the client meets the admission criteria for a more intensive type of service.
4. **Treatment Acceptance/Resistance**

**Discharge:**
The client’s awareness and acceptance of an addiction problem and commitment to recovery is sufficient to expect maintenance of a self-directed recovery plan as evidenced by:
1. Recognition of the severity of his/her alcohol/drug use, AND
2. An understanding of his/her self-defeating relationship with alcohol/drugs, AND
3. Application of the essential skills necessary to maintain sobriety in a mutual/self-help fellowship and/or with post-treatment supportive care, AND
4. The client does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:
A. The client has consistently failed to achieve essential treatment objectives, despite revisions to the treatment plan, to the degree that no further progress is likely to occur at this type of service. However, the client does meet the Admission Criteria for a more intensive type of service;
B. The client does not meet any of the Level 1A Continued Stay Criteria and meets Admission Criteria for another type of service.

5. **Relapse Potential**

**Discharge:**
The client’s therapeutic gains, which address craving and relapse issues, have been integrated and internalized, and the client does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
The client is experiencing an exacerbation in drug-seeking behaviors or craving that necessitates treatment AND the client meets the Admission Criteria for a more intensive type of service.

6. **Recovery Environment**

**Discharge:**
Clients must meet ONE of the following:
A. The client’s social system and significant others are supportive of recovery to the extent that the client can adhere to a self-directed recovery plan without substantial risk of relapse, and he/she does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service;
B. The client is functioning adequately in assessed deficiencies in the life task areas of work, social functioning, or primary relationships, and the client does not meet any of the Level 1A Continued Stay Criteria OR Admission Criteria for any other type of service.

**Referral:**
The client’s social system remains non-supportive or has deteriorated. The client is having difficulty coping with this environment and is at substantial risk of reactivating his/her addiction AND the client meets the Admission Criteria for another type of service.
Level 1B
Intensive Outpatient

Description of Service Level

- Intensive Outpatient treatment is an organized, non-residential treatment service in which the client resides outside the facility. It provides structured psychotherapy and client stability through increased periods of staff intervention. These services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week for at least 5 hours (but less than 10).
- Intensive outpatient treatment may be provided at any Pennsylvania Department of Health licensed drug and alcohol facility, as stipulated in 28 PA Code under the Outpatient regulations.
- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio is not to exceed 35:1; due to the intensity of the services provided, it is recommended that the client:staff ratio not exceed 15:1.

Required Services and Support Systems include:
- Biopsychosocial Assessment
- Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 60 days (recommended: every 30 days)
- Psychotherapy, including individual, group, and family (per clinical evaluation)
- Aftercare planning and follow-up
- Development of discharge plan and plan for referral into continuum of care

Recommended Services and Support Systems include:
- Psychoeducational seminars
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive levels of care, as clinically indicated
- Emergency telephone line available when program is not in session
- Collaboration between the treatment team and various agencies for the coordinated provision of services

- Occupational and vocational counseling
• Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs

The Required Staff at an intensive outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.
### Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 1B criteria in Dimensions 3, 4, and 5, and no criteria higher than Level 1B in the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet all of the following:</td>
</tr>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
</tr>
<tr>
<td>A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</td>
</tr>
<tr>
<td>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol with no medication; OR</td>
</tr>
<tr>
<td>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</td>
</tr>
<tr>
<td>3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.</td>
</tr>
<tr>
<td>B. For clients with withdrawal symptoms no more severe than those noted above, the client has, and responds positively to, emotional support and comfort as evidenced by:</td>
</tr>
<tr>
<td>1. Decreased emotional symptoms by the end of the initial interview session, AND</td>
</tr>
<tr>
<td>2. Home environment able to provide adequate support.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
</tr>
<tr>
<td>A. The client’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;</td>
</tr>
<tr>
<td>B. The client’s biomedical conditions and problems are not severe enough to warrant inpatient treatment, but are sufficient to distract from recovery efforts. Such problems require medical monitoring and/or medical management (at least 3 days per week with between 5 and 10 contact hours per week) which can be provided by the intensive outpatient program or through concurrent arrangement with another treatment provider.</td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
</tr>
<tr>
<td>A. The client may exhibit emotional distress, but he or she is able to maintain behavioral stability over a period of time between treatment contacts (2-4 days).</td>
</tr>
<tr>
<td>B. The client’s problems may be secondary to the addiction or may reflect an independent psychopathology, but they are able to be stabilized with ancillary treatment or medication, and do not present an obstruction to the patient’s participation in treatment or to the therapeutic milieu.</td>
</tr>
<tr>
<td>C. The mental status of the client does not preclude his/her ability to:</td>
</tr>
<tr>
<td>1. Comprehend and understand the materials presented, and</td>
</tr>
<tr>
<td>2. Participate in the treatment process.</td>
</tr>
<tr>
<td>D. The client is assessed as being at no more than a mild risk of endangering self or others (e.g. suicidal or homicidal thoughts with no active plan).</td>
</tr>
</tbody>
</table>
4. **Treatment Acceptance/Resistance**

Clients must meet all of the following:

A. The client may acknowledge the presence of a problem, but minimizes the impact of the addiction on his/her life, and displays limited insight into the problem.

B. The client displays limited understanding of the process of recovery.

C. The client is willing to participate in the level of care.

5. **Relapse Potential**

The client is assessed as being able to maintain abstinence and recovery goals only with support and scheduled therapeutic contact to help to deal with such issues as, but not limited to, mental preoccupation with alcohol/drug use, limited insight regarding relapse triggers, craving, peer pressures, lifestyle, attitudinal changes, and difficulty postponing gratification.

6. **Recovery Environment**

Clients must meet ONE of the following:

A. A sufficiently supportive psychosocial environment that makes outpatient treatment feasible (e.g. significant others who are in agreement with recovery efforts, supportive work or legal coercion, adequate transportation to the program, and support meetings and non-alcohol/drug centered work that are accessible and near the home);

B. Client has demonstrated motivation and willingness to obtain an ideal primary or social support system to assist with immediate sobriety, even though he/she does not presently have such a support system;

C. Family/significant others are supportive, but the client requires professional interventions to improve chances of treatment success and recovery (e.g. assistance in limit-setting, communication skills, and a decrease in rescuing behaviors, etc.).
### Dimensional Scoring Specifications
Clients must meet, at a minimum, Level 1B criteria in Dimensions 3, 4, and 5, and no criteria higher than Level 1B in the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **1. Acute Intoxication or Withdrawal** | Clients must meet ONE of the following:  
A. Acute symptoms of intoxication/withdrawal are absent in the client;  
B. Client exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance abuse, high levels of anxiety, etc.) which present obstacles to engaging in recovery and normal life functioning;  
C. Client reports a limited lapse of sobriety that can be addressed constructively. |
| **2. Biomedical Conditions and Complications** | Clients must meet ONE of the following:  
A. Any biomedical conditions, if present, continue to be sufficiently stable to permit continued participation in outpatient treatment;  
B. An intervening biomedical condition or event was serious enough to interrupt treatment, but the client is again progressing in treatment. |
| **3. Emotional/Behavioral Conditions and Complications** | Clients must meet ONE of the following:  
A. The client continues to be unable to maintain behavioral stability over a 3-5 day period, but the behavioral stability problem is actively being addressed in treatment, and there are indications that the client is responding to treatment interventions;  
B. The client’s emotional/behavioral disorder, which is being concurrently managed, continues to distract the client from treatment, but the client is responding to treatment and it is anticipated that with further interventions, he/she will be able to achieve treatment objectives;  
C. The client continues to manifest mild risk behaviors endangering self or others (e.g. diminishing suicidal or homicidal thoughts), but the condition is improving. |
| **4. Treatment Acceptance/Resistance** | The client is beginning to recognize that he/she is responsible for addressing his/her illness, but still requires the level of intensity of motivating strategies to sustain personal responsibility in treatment. |
| **5. Relapse Potential** | Clients must meet ONE of the following:  
A. Client recognizes relapse potential but has not yet identified sufficient relapse triggers, or has not yet consistently developed and applied behavioral changes to interrupt or postpone gratification or to change the related inadequate impulse control necessary to maintain abstinence;  
B. Client continues to require multiple structured contacts per week to sustain abstinence. |
| 6. Recovery Environment | Clients must meet ONE of the following:
A. The social support environment remains non-supportive or has deteriorated, but the client is making sufficient progress in learning social and related coping skills to contend with the environment;
B. The social system is supportive of recovery, but the client is not yet able to adhere to a self-directed recovery plan without substantial risk of reactivating substance use. |
## Level 1B (Intensive Outpatient care)
### Discharge/Referral Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Discharge:</th>
<th>Referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Acute Intoxication or Withdrawal</strong></td>
<td>Clients must meet all of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is assessed as not being in intoxication or withdrawal,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client does not manifest symptoms of protracted withdrawal syndrome,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. The client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is abusing alcohol/drugs, and is in need of a more intensive type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client does not meet any of the Level 1B Continued Stay criteria, but DOES meet the Admission criteria for a lesser type of service.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Biomedical Conditions and Complications</strong></td>
<td><strong>Discharge:</strong> Client’s biomedical problems, if any, have diminished or stabilized to the extent that they can be managed through outpatient appointments.</td>
<td><strong>Referral:</strong> There is a biomedical condition that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
<tr>
<td>3. <strong>Emotional/Behavioral Conditions and Complications</strong></td>
<td><strong>Discharge:</strong> Clients must meet ONE of the following:</td>
<td><strong>Referral:</strong> A psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
<tr>
<td></td>
<td>A. The client’s emotional/behavioral problems have diminished in acuity to the extent that regular monitoring of behaviors is no longer necessary, and the client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client is no longer assessed as being at risk of addiction-related abuse or neglect of spouse, children, or significant others, and the client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
</tbody>
</table>
### 4. Treatment Acceptance/Resistance

**Discharge:**
The client’s awareness and acceptance of an addiction problem and commitment to recovery is sufficient to expect maintenance of a self-directed recovery plan, as evidenced by:
1. Client is able to recognize the severity of his/her alcohol/drug use,
2. Client has an understanding of his/her self-defeating relationship with alcohol/drugs,
3. Client is applying the essential skills necessary to maintain sobriety in a mutual/self-help fellowship with post-treatment supportive care, and
4. Client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client has consistently failed to achieve essential treatment objectives, despite revisions to the treatment plan, to the extent that no further progress is likely to occur in this type of service. The client does, however, meet the Admission criteria for another type of service;

B. The client does not meet any of the Level 1B Continued Stay criteria and meets the Admission criteria for another type of service.

### 5. Relapse Potential

**Discharge:**
The client’s therapeutic gains that address craving and relapse issues have been sufficiently integrated into his/her daily behavior to support an ongoing care program, and the client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client is experiencing an intensification of addiction symptomatology (e.g. craving, or return to regular use of psychoactive substances) despite continued interventions, and the client meets the Admission criteria for a more intensive type of service;

B. The client meets the Admission criteria for another type of service.
6. Recovery Environment

**Discharge:**
Clients must meet ONE of the following:

A. The client’s social system and significant others are supportive of recovery to the extent that the client can adhere to a self-directed recovery plan without substantial risk of relapse, and the client does not meet any of the Level 1B Continued Stay criteria OR the Admission criteria for any other type of service;

B. The client is functioning adequately in assessed deficiencies in the life task areas of work, social functioning, and primary relationships, and does not meet any of the Level 1B Continued Stay criteria or the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client’s social system remains non-supportive or has deteriorated. The client is having difficulty coping with this environment and is at substantial risk of reactivating his/her addiction, and the client meets the Admission criteria for a more intensive type of service;

B. The client meets the Admission criteria for another type of service.

---

**Level 2A**

**Partial Hospitalization**

**Description of Service Level**

- Partial Hospitalization treatment consists of the provision of psychiatric, psychological, and other types of therapies on a planned and regularly scheduled basis in which the client reside outside the facility. This service is designed for those clients who do not require 24-hour residential care, but who would nonetheless benefit from more intensive treatments than are offered in outpatient treatment projects. The environment provides multi-modal strategies and multi-disciplinary psychotherapy along with other ancillary services. Partial hospitalization services consist of regularly scheduled treatment sessions at least 3 days per week, with a minimum of 10 hours per week.

- These services may be conducted at any Pennsylvania Department of Health licensed drug and alcohol facility, as stipulated in 28 PA Code.

- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio is not to exceed 10:1.

**Required Services and Support Systems include:**
- Biopsychosocial Assessment
- Specialized professional/medical consultation, and tests such as a physical
examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed

- Individualized treatment planning, with review at least every 30 days
- Individual therapy 2 times per week
- Group therapy 2 times per week (recommended group size: no more than 12)
- Couples therapy (as appropriate)
- Family therapy (as appropriate)
- Development of discharge plan and plan for referral into continuum of care
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

Recommended Services and Support Systems include:

- Psychoeducational seminars
- Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic needs
- Structured positive social activities available within non-program hours, including evenings and weekends
- Access to more intensive levels of medical or psychiatric care, as clinically indicated
- Emergency telephone line available when program is not in session
- Supportive/cooperative work programs
- Collaboration between the treatment team and various agencies for the coordinated provision of services

The Required Staff at a Partial Hospitalization care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.
# Level 2A (Partial Hospitalization)

## Admission Criteria across 6 Dimensions

### Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 2A criteria in Dimensions 3 and 5, and no criteria higher than Level 2A for the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 1. Acute Intoxication or Withdrawal | Clients must meet all of the following:  
A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:  
   1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR  
   2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR  
   3. Sub-acute symptoms of protracted withdrawal that, if present, can be managed safely without daily monitored medical intervention.  
B. For clients with withdrawal symptoms no more severe than those noted above, the client has, and responds positively to, emotional support and comfort as evidenced by:  
   1. Decreased emotional symptoms by the end of the initial treatment session, and  
   2. Home environment capable of providing adequate reality, reassurance, and respect. |
| 2. Biomedical Conditions and Complications | Clients must meet ONE of the following:  
A. The client’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;  
B. The client exhibits a medical problem not severe enough to warrant 24-hour observation, but sufficiently distracting from recovery efforts as to require more frequent attention (at least 3 days per week with a minimum of 10 hours per week);  
C. The presence of a medical problem which would be severely exacerbated by a relapse. |
### 3. Emotional/Behavioral Conditions and Complications

Clients must meet at least 2 of the following:

A. Current inability to maintain behavioral stability over 72-hour period (e.g. distractibility, negative emotions, generalized anxiety, etc.);

B. Diagnosed but stable major emotional/behavioral disorder which requires monitoring and/or management due to a history indicating its high potential of distracting the client from recovery and/or treatment (e.g. borderline personality disorder);

C. The client has some mental impairments that present minor problems in his/her ability to:
   1. Comprehend and understand the materials presented, and
   2. Participate in treatment;

D. Mild risk of behaviors endangering self or others (e.g. suicidal or homicidal ideation with no active plan);

E. Addiction-related abuse or neglect of spouse, children, or significant others, requiring partial treatment to reduce the risk of further deterioration.
<table>
<thead>
<tr>
<th>4. <strong>Treatment Acceptance/Resistance</strong></th>
<th>Client requires structured therapy and programmatic milieu to promote treatment progress and recovery, because he/she attributes alcohol/drug problems to other persons or external events, and not his/her personal addiction. This inhibits his/her ability to make behavioral changes without clinically directed and repeated motivating interventions. The client's resistance, however, is not so high as to render the treatment ineffective.</th>
</tr>
</thead>
</table>
| 5. **Relapse Potential** | Clients must meet ONE of the following:  
A. Despite active participation in treatment, the client is experiencing an intensification of addiction symptoms (e.g. difficulty postponing immediate gratification and related drug-seeking behavior), and the individual is deteriorating in his/her level of functioning despite revisions in the treatment plan;  
B. High likelihood of drinking or drug use without close monitoring and structured support as indicated by, for example, lack of awareness of relapse triggers, difficulty postponing immediate gratification, and/or ambivalence or resistance to treatment. |
| 6. **Recovery Environment** | Clients must meet ONE of the following:  
A. Family members and/or significant others living with the client are non-supportive of recovery goals and/or passively opposed to his/her treatment. Client requires relief from home environment during the day or evening to stay focused on recovery, but may return home because there is no active opposition or sabotaging of recovery efforts;  
B. Lack of social contacts jeopardizes recovery (e.g. client lives alone and has few friends or peers who don’t use alcohol/drugs). |
## Level 2A (Partial Hospitalization)
### Continued Stay Criteria across 6 Dimensions

**Dimensional Scoring Specifications**

Clients must meet, at a minimum, Level 2A criteria in Dimensions 4, 5, and 6, and no criteria higher than Level 2A for the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. Acute symptoms of intoxication/withdrawal are absent in the client;</td>
</tr>
<tr>
<td></td>
<td>B. Client exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</td>
</tr>
<tr>
<td></td>
<td>C. The client reports a limited lapse of sobriety that can be addressed constructively at this LOC.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The biomedical conditions and problems, if any, continue to be present, yet are not severe enough to interfere with treatment;</td>
</tr>
<tr>
<td></td>
<td>B. The client is responding to treatment, and biomedical conditions and problems continue not to be severe enough to warrant inpatient treatment, but they are sufficient to distract from recovery efforts. Such problems require medical monitoring which can be provided at Level 2A.</td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The client continues to be unable to maintain behavioral stability over a 3-5 day period, but the behavioral instability problem is actively being addressed in treatment, and there are indications that the client is responding to treatment interventions;</td>
</tr>
<tr>
<td></td>
<td>B. The client’s emotional/behavioral disorder, which is being concurrently managed, continues to distract the client from treatment, but the client is responding to treatment, and it is anticipated that with further interventions, he/she will be able to achieve treatment objectives;</td>
</tr>
<tr>
<td></td>
<td>C. The client continues to manifest mild risk behaviors endangering self or others (e.g. diminishing suicidal or homicidal thoughts), but the condition is improving.</td>
</tr>
<tr>
<td>4. Treatment Acceptance/Resistance</td>
<td>The client is beginning to demonstrate personal responsibility for addressing his/her substance abuse and recovery, but continues to require intensive structured treatment, motivating strategies, and/or consistent peer support in order to sustain and internalize recovery efforts.</td>
</tr>
</tbody>
</table>
5. **Relapse Potential**

Clients must meet ONE of the following:

A. The client recognizes relapse potential, but has not yet sufficiently identified relapse triggers or consistently developed and applied behavioral changes to interrupt or postpone gratification or to change the related inadequate impulse control necessary to maintain abstinence;

B. The client continues to be dependent on the program structure for sustaining abstinence.

6. **Recovery Environment**

Clients must meet ONE of the following:

A. The client has not yet developed sufficient coping skills to withstand stressors presented by non-supportive family, work, or neighborhood environment, but has recognized the need to do so;

B. The client has not yet integrated the socialization skills necessary to establish a supportive social network.
### Level 2A (Partial Hospitalization)
#### Discharge/Referral Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Discharge</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td>Clients must meet all of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is assessed as not being in intoxication or withdrawal,</td>
<td></td>
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<tr>
<td></td>
<td>B. The client does not manifest symptoms of protracted withdrawal syndrome, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. The client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is abusing alcohol/drugs, and meets the Admission criteria for a more intensive type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client does not meet any of the Level 2A Continued Stay criteria, but does meet the Admission criteria for a lesser type of service.</td>
<td></td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td><strong>Discharge:</strong></td>
<td>There is a biomedical condition that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
<tr>
<td></td>
<td>The client’s biomedical problems, if any, have diminished or stabilized to the extent that they can be managed in a less intensive type of service, and the client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td><strong>Discharge:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client’s emotional/behavioral problems have diminished in acuity to the extent that regular monitoring of behaviors is no longer necessary, and the client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client is no longer assessed as being at risk of addiction-related abuse or neglect of spouse, children, or significant others, and does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral:</strong></td>
<td>A psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>
### 4. Treatment Acceptance/Resistance

**Discharge:**
The client no longer requires this level of intensive clinically-directed motivating interventions, as evidenced by all of the following:
1. Client is able to recognize the severity of his/her alcohol/drug problem,
2. Client understands his/her self-defeating relationship with alcohol/drugs,
3. Client is beginning to apply the essential skills necessary to maintain sobriety in a mutual/self-help fellowship with continuing treatment in a less intensive type of service, AND
4. Client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan, to the extent that no further progress is likely to occur at this level of care; however, the client meets the Admission criteria for another type of service;

B. The client does not meet any of the Level 2A Continued Stay criteria and meets Admission criteria for another type of service.

### 5. Relapse Potential

**Discharge:**
The client has identified relapse triggers and has developed appropriate coping strategies to deal with them. He/she has also integrated these behaviors sufficiently to be able to support a self-directed recovery plan. The client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client is experiencing an intensification of addiction symptomatology (e.g. craving, return to regular use of psychoactive substances) despite continued interventions, and the client meets the Admission criteria for a more intensive type of service;

B. The client meets the Admission criteria for another type of service.
| 6. Recovery Environment | **Discharge:**
| | Clients must meet ONE of the following:
| | A. Problem aspects of the client's social and interpersonal environment are responding to treatment, and the environment is sufficiently supportive of recovery to allow discharge or transfer to a more appropriate level of care, and the client does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service;
| | B. The social and interpersonal environment has not changed or has deteriorated, but the client has learned skills to cope with the current situation, or has secured an alternative environment, and does not meet any of the Level 2A Continued Stay criteria OR the Admission criteria for any other type of service.

| | **Referral:**
| | Clients must meet ONE of the following:
| | A. The social system remains non-supportive or has deteriorated. The client is having difficulty coping with this environment and is at substantial risk of reactivating his/her addiction, and he/she meets the Admission criteria for a more intensive type of service;
| | B. The client meets the Admission criteria for another type of service.
Level 2B
Halfway House

Description of Service Level

- A Halfway House is a community-based residential treatment and rehabilitation facility that provides services for chemically dependent persons in a supportive, chemical-free environment. While this setting does provide substance abuse treatment, it also emphasizes protective and supportive elements of family living, and encourages and provides opportunities for independent growth and responsible community living. Mutual self-help, assistance in economic/social adjustment, and integration of life skills into daily life, as well as a solid program of recovery, are also encouraged. Clients entering this environment must have already had some experience in another type of drug and alcohol treatment. A Halfway House is a live in/work out environment, with a typical length of stay being 3 to 6 months.

- This treatment must be conducted in a Pennsylvania Department of Health licensed drug and alcohol non-hospital facility, as stipulated in 28 PA Code. The setting is usually an independent physical structure containing no more than 25 beds. This type of facility is meant to provide a “home-like” atmosphere within the local community, be accessible to public transportation, and give no indication of being an institutional setting. Normal housekeeping and food preparation are done on the premises by the clients.

- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio must not exceed 8:1, although halfway houses may petition the Department of Health for exceptions to these client:staff ratios.

Required Services and Support Systems include:

- Physical exam
- Regularly scheduled psychotherapy
- Biopsychosocial Assessment
- Specialized professional/medical consultation, and tests such as a psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 30 days
- Development of a discharge plan and a plan for referral into continuum of care
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)
Recommended Services and Support Systems include:
- Group therapy once per week for at least 1.5 hours per session (group size: no more than 12)
- Individual therapy at least twice a month for at least one hour per session
- Peer group meetings four times per week for at least 45 minutes per session, to focus on daily living
- Family therapy, if indicated by the individual’s treatment plan
- Educational or instructional groups, once per month

The Required Staff in a halfway house include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.
Level 2B (Halfway House)
Admission Criteria across 6 Dimensions

### Dimensional Scoring Specifications
Clients must meet, at a minimum, Level 2B criteria for Dimension 3, and Level 2B criteria from two of either Dimensions 4, 5, or 6. Clients must not meet criteria that are higher than Level 2B in Dimensions 1 or 2.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td>Clients must meet all of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</td>
</tr>
<tr>
<td></td>
<td>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</td>
</tr>
<tr>
<td></td>
<td>3. Sub-acute symptoms of protracted withdrawal, if present, can be managed safely without daily monitored medical intervention.</td>
</tr>
<tr>
<td></td>
<td>B. For clients with withdrawal symptoms no more severe than those noted above, the client has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial treatment session.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The client’s biomedical conditions and problems, if any, are not severe enough to interfere with treatment;</td>
</tr>
<tr>
<td></td>
<td>B. The client’s biomedical conditions and problems are not severe enough to warrant Level 3 or Level 4 treatment, but are sufficient to distract from recovery efforts. Such problems require medical monitoring and/or medical management which can be provided by the Level 2B program, or through a concurrent arrangement with another treatment provider;</td>
</tr>
<tr>
<td></td>
<td>C. The client needs help with referral to educational resources for management of his or her own health care needs;</td>
</tr>
<tr>
<td></td>
<td>D. Abstinence is essential if overall health is to return.</td>
</tr>
</tbody>
</table>
### 3. Emotional/Behavioral Conditions and Complications

Clients must meet at least 2 of the following:

A. Inability to maintain behavioral stability (e.g. lacks impulse control);

B. Mental status of client does not preclude his or her ability to comprehend and understand the materials presented or to participate in the treatment process;

C. The client is manifesting stress behaviors related to recent or threatened losses in the work, family, or social arena to the extent that activities of daily living are significantly impaired;

D. Mild risk of behaviors endangering self or others (e.g. suicidal or homicidal thoughts with no active plan);

E. The client needs reinforcement to improve cognitive skills and gain basic social functions;

F. Low self-esteem and limited ability to make decisions;

G. Coexisting emotional/behavioral/psychiatric conditions can be treated through referral agreements

### 4. Treatment Acceptance/Resistance

Clients must meet all of the following:

A. The client expresses willingness to cooperate and attend all scheduled activities, and

B. The client admits that he or she has an alcohol and/or other drug problem, and accepts the need for monitoring and motivating strategies in a 24-hr structured living environment.

### 5. Relapse Potential

Clients must meet ONE of the following:

A. Likelihood of drinking or other drug use without a 24-hr structured living environment (inability to integrate treatment/recovery process);

B. Client lacks awareness of relapse triggers and has difficulty postponing immediate gratification.

### 6. Recovery Environment

Clients must meet ONE of the following:

A. Family members and/or significant others living with the client are non-supportive of recovery goals and/or passively opposed to his/her treatment. Client requires 24-hr relief from home environment to stay focused on recovery;

B. Lack of social contacts which jeopardizes recovery (e.g. client lives alone, has few friends or peers who don’t use alcohol/drugs);

C. Logistic impediments (e.g. distance from treatment facility, mobility limitations, lack of drivers license, etc.) preclude participation in treatment services at a less intensive level;

D. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the client’s current environment that will make recovery unlikely without removing the individual from this environment.
## Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 2B criteria in Dimensions 3, 5, and 6, and no criteria higher than Level 2B in the remaining dimensions.

### 1. Acute Intoxication or Withdrawal

Clients must meet ONE of the following:

- A. Acute symptoms of intoxication/withdrawal are absent in the client;
- B. Client presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;
- C. Client reports a limited lapse of sobriety, but this can be addressed constructively.

### 2. Biomedical Conditions and Complications

The client is responding to treatment, and biomedical conditions and problems continue not to be severe enough to warrant a higher level of care, but they are sufficient to distract from recovery efforts. Such problems require medical monitoring which the client learns to access by using community resources.

### 3. Emotional/Behavioral Conditions and Complications

Clients must meet ONE of the following:

- A. Client continues to demonstrate unstable behavior (e.g. impulse control) but shows improvement;
- B. Stress factors continue to threaten treatment process in daily living arrangements, but there is evidence of improvement;
- C. Risk of endangering self or others continues or is diminishing;
- D. Client demonstrates improvement in cognitive skills and basic social functions but continues to need reinforcement;
- E. Decision-making and self-esteem improving but still need reinforcement.

### 4. Treatment Acceptance/Resistance

The client recognizes the severity of his or her alcohol/drug problems and manifests understanding of his/her personal relationship with psychoactive substances, yet does not demonstrate that he/she has assumed the responsibility necessary to cope with the problem.

### 5. Relapse Potential

Client recognizes the severity of his/her relapse triggers and dysfunctional behaviors which undermine sobriety, and manifests an understanding of these dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills necessary to maintain ongoing abstinence.
| 6. Recovery Environment | Clients must meet ONE of the following:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Client has not integrated sufficient coping skills to withstand stressors in the work environment or has not developed vocational alternatives;</td>
</tr>
<tr>
<td></td>
<td>B. Client has not yet developed sufficient coping skills to deal with the non-supportive family/social environment;</td>
</tr>
<tr>
<td></td>
<td>C. Client has not yet integrated the socialization skills necessary to establish a supportive social network.</td>
</tr>
</tbody>
</table>
### Level 2B (Halfway House)  
**Discharge/Referral Criteria across 6 Dimensions**

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet Level 2B criteria for all six dimensions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Acute Intoxication or Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge:</strong></td>
</tr>
<tr>
<td>Clients must meet all of the following:</td>
</tr>
<tr>
<td>A. The client is assessed as not being in intoxication or withdrawal,</td>
</tr>
<tr>
<td>B. The client does not manifest symptoms of protracted withdrawal syndrome, and</td>
</tr>
<tr>
<td>C. The client does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
</tr>
<tr>
<td><strong>Referral:</strong></td>
</tr>
<tr>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td>A. The client is abusing alcohol or other drugs and is in need of a more intensive type of service;</td>
</tr>
<tr>
<td>B. The client does not meet any of the Level 2B Continued Stay criteria, but does meet the Admission criteria for a lesser type of service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Biomedical Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge:</strong></td>
</tr>
<tr>
<td>The client’s biomedical problems, if any, have diminished or stabilized to the extent that the client is capable of managing his own health care needs, and the client does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
</tr>
<tr>
<td><strong>Referral:</strong></td>
</tr>
<tr>
<td>There is a biomedical condition that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Emotional/Behavioral Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge:</strong></td>
</tr>
<tr>
<td>Emotional/behavioral problems (e.g. stress factors and impulse controls) have mitigated, and the client can regulate own behavior without regular medical monitoring, and the client does not meet the Admission criteria for any other type of service.</td>
</tr>
<tr>
<td><strong>Referral:</strong></td>
</tr>
<tr>
<td>An emotional/behavioral condition exists that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>
### 4. Treatment Acceptance/Resistance

<table>
<thead>
<tr>
<th><strong>Discharge:</strong></th>
<th>The client’s awareness and acceptance of an addiction problem and commitment to recovery is sufficient to expect maintenance of a self-directed recovery plan as evidenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. The client is able to recognize the severity of his/her drug/alcohol problem,</td>
</tr>
<tr>
<td></td>
<td>2. The client understands his/her self-defeating relationship with alcohol/drugs and understands his/her triggers and dysfunctional behaviors which lead to alcohol/drug use,</td>
</tr>
<tr>
<td></td>
<td>3. The client is applying the essential skills necessary to maintain sobriety in a mutual/self-help fellowship with post-treatment supportive care, AND</td>
</tr>
<tr>
<td></td>
<td>4. The client does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
</tr>
<tr>
<td><strong>Referral:</strong></td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The client has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan, to the degree that no further progress is likely to occur at this level of service. However, the client meets the Admission criteria for another type of services;</td>
</tr>
<tr>
<td></td>
<td>B. The client does not meet any of the Level 2B Continued Stay criteria but meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>

### 5. Relapse Potential

| **Discharge:** | The client is capable of following and completing a specific continuing care recovery plan. Client’s integration of therapeutic gains is established sufficiently that the client does not appear at risk of imminent relapse, and the client does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service. |
| **Referral:**  | Clients must meet ONE of the following:                                                                                                                                                                     |
|               | A. The client is experiencing an intensification of addiction symptomatology (e.g. craving, return to regular use of psychoactive substances) despite continued interventions, and meets the Admission criteria for a more intensive type of service; |
|               | B. The client meets the Admission criteria for another type of service.                                                                                                                                       |
### 6. Recovery Environment

#### Discharge:
Clients must meet ONE of the following:

A. Problem areas in the client’s social and interpersonal environment are responding to treatment and the environment is sufficiently supportive of recovery to allow discharge, and the client does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service;

B. The social and interpersonal environment has not changed or has deteriorated, but the client has learned skills to cope with the current situation or has secured an alternative environment, and he/she does not meet any of the Level 2B Continued Stay criteria OR the Admission criteria for any other type of service.

#### Referral:
Clients must meet ONE of the following:

A. Client continues to remain at risk for relapse and meets the Admission criteria for another type of service;

B. The client meets the Admission criteria for another type of service.
Level 3A
Medically Monitored Inpatient Detoxification

Description of Service Level

- Medically Monitored Inpatient Detoxification is a treatment conducted in a residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted clients. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent client is assisted through the period of time required to eliminate the presence of the intoxicating substance (by metabolic or other means) and any other dependency factors while keeping the physiological and psychological risk to the client at a minimum. This process should also include efforts to motivate and support the client to seek formal treatment after the detoxification process. This type of care utilizes multi-disciplinary personnel for clients whose withdrawal problems (with or without biomedical and/or emotional problems) are severe enough to require inpatient services, 24-hour observation, monitoring, and, usually, medication. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment system are not necessary. This treatment is specific to psychoactive substance use. The multi-disciplinary team and the availability of support services allows detoxification and a level of treatment consistent with the client’s mental state and required length of stay, as well as the conjoint treatment of any coexisting sub-acute biomedical or emotional conditions which could jeopardize recovery.
- Treatment is conducted in a Pennsylvania Department of Health licensed drug and alcohol non-hospital detoxification service, located in a freestanding or health care-specific environment.
- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor (or Primary Care Staff Person) ratio must not exceed 7:1 during primary care hours.

Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Emergency medical services available
- Referral to medically managed detox, if clinically appropriate
- Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed
- Biopsychosocial Assessment
- Monitoring of medication, as needed
- Development of discharge plan, and plan for referral into continuum care
- Medications ordered by a licensed physician and administered in accordance
with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures

- Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician with 24 hours following admission
- Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of clients found to have such illnesses, so as to protect other clients and staff from acquiring these diseases.
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

**Recommended Services and Support Systems include:**

- Ability to conduct and/or arrange for appropriate laboratory and toxicology tests
- 24-hour physician available by telephone
- Face-to-face assessment by a physician within 24 hours after admission, with further assessments thereafter as medically needed (but not less than 3 times per week)
- Alcohol- or drug-focused nursing assessment by a registered nurse upon admission
- Oversight and monitoring of the client’s progress and medication administration by licensed medical staff under the physician’s direction
- Professional counseling services available 12 hours a day, provided by appropriately qualified staff
- Health education services
- Clinical program activities designed to enhance the client’s understanding of his/her addiction
- Family/significant other services, as appropriate

The Required Staff at a medically monitored inpatient detox facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.

**Level 3A (Medically Monitored Inpatient Detox)**

**Admission Criteria across 6 Dimensions**
## Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 3A criteria for Dimension 1, and no criteria higher than Level 3A for Dimensions 2 and 3.

<table>
<thead>
<tr>
<th>1. Acute Intoxication or Withdrawal</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. The risk of a severe withdrawal syndrome is present but manageable in this setting, as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>1. Client is withdrawing from alcohol and CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) equals 10-19; OR</td>
</tr>
<tr>
<td></td>
<td>2. Daily ingestion of sedative hypnotics or opioids for over six months, plus daily use of another mind-altering drug known to have its own withdrawal syndrome (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR</td>
</tr>
<tr>
<td></td>
<td>3. Daily ingestion of sedative hypnotics or opioids above the recommended therapeutic dosage level for at least 4 weeks (close hourly monitoring is available, if needed), with no accompanying chronic mental/physical disorder; OR</td>
</tr>
<tr>
<td></td>
<td>4. The client uses high dose/oral/nasal stimulants, or smokes or injects stimulants at least once a day in a cyclic pattern of “runs,” and is currently within 7 days of such drug use; OR</td>
</tr>
<tr>
<td></td>
<td>5. The client has marked lethargy, hyposomnolence, or high levels of agitation associated with expressed high degrees of drug craving.</td>
</tr>
<tr>
<td></td>
<td>B. The client is either not showing signs of intoxication with a blood alcohol of .15gm% or greater, or has a blood alcohol level of 0.2gm%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Biomedical Conditions and Complications</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Continued alcohol/drug use places the client in imminent danger of serious damage to physical health for concomitant biomedical conditions;</td>
</tr>
<tr>
<td></td>
<td>B. Biomedical complications of addiction or a concurrent biomedical illness require medical monitoring, but not intensive care.</td>
</tr>
</tbody>
</table>
### 3. Emotional/Behavioral Conditions and Complications

Clients must meet ONE of the following:

**A.** Depression and/or other emotional/behavioral symptoms (e.g. compulsive behavior) are sufficiently interfering with abstinence, recovery, and stability to the degree that there is a need for a structured 24-hour environment to address recovery efforts;

**B.** Moderate risk of behaviors endangering self or others (e.g. current suicidal or homicidal thoughts with no active plan, but with a history of suicidal/homicidal gestures or threats);

**C.** Manifesting high stress behaviors related to recent or threatened losses in the work, family, or social arena, to the extent that activities of daily living are significantly impaired. A 24-hr structured setting is needed to place the client in a secure environment to address his or her addiction;

**D.** History or presence of violent or disruptive behavior during intoxication with imminent danger to self or others, or boundary-setting difficulties;

**E.** Concomitant personality disorder (e.g. antisocial personality disorder with verbal aggressive behavior requiring constant limit-setting) is of such severity that the accompanying dysfunctional behaviors require continuous monitoring.

<table>
<thead>
<tr>
<th>4. Treatment Acceptance/Resistance</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Relapse Potential</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Level 3A (Medically Monitored Inpatient Detox)  
Continued Stay Criteria across 6 Dimensions

### Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 3A criteria for Dimension 1, and Level 3A criteria from one of Dimensions 3, 4, or 6. Clients cannot meet criteria higher than Level 3A for the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 1. Acute Intoxication or Withdrawal | Clients must meet ONE of the following:  
A. Persistence of withdrawal symptomatology, and/or withdrawal protocol, requires continued medical and/or nursing monitoring on a 24-hr basis;  
B. Post-withdrawal organicity (e.g. poor immediate and recent memory recall) inhibits cognitive functioning and the client’s ability to effectively achieve treatment objectives, but the client’s cognition is clearing and he/she is expected to respond to treatment. |
| 2. Biomedical Conditions and Complications | Continuation of any biomedical problem which prohibits transfer to another level of care. |
| 3. Emotional/Behavioral Conditions and Complications | Clients must meet ONE of the following:  
A. The client is making progress toward resolution of an emotional or behavioral problem, but he/she has not sufficiently resolved the problem(s) to permit transfer to another level of care;  
B. The client is being held pending transfer (within 48 hours) to a more intensive inpatient service. |
| 4. Treatment Acceptance/Resistance | The client recognizes the severity of the alcohol/drug problems, but demonstrates minimal understanding of his/her self-defeating use of alcohol or drugs. |
| 5. Relapse Potential | N/A |
| 6. Recovery Environment | Continuing danger of physical, sexual, and/or severe emotional attack or victimization in the client’s outside environment will make recovery unlikely without removing the individual from this environment. |
Level 3A (Medically Monitored Inpatient Detox)
Discharge/Referral Criteria across 6 Dimensions

### Dimensional Scoring Specifications
Clients must meet Level 3A criteria in all dimensions EXCEPT for Dimension 5.

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
<th>Discharge:</th>
<th>Referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td>N/A</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. The client is assessed as not being intoxicated or in acute alcohol or other drug withdrawal, and does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment in this dimension. Therefore, the client is to be assessed for referral to the appropriate type of service;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. The client has protracted withdrawal symptoms which no longer require 24-hr monitoring as they are not associated with craving for the drug or alcohol, and the client does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment in this dimension. Therefore, the client is to be assessed for referral to the appropriate type of service.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Client’s biomedical problems, if any, have diminished or stabilized to the extent that daily medical and nursing monitoring for the condition is no longer necessary, and the client does not meet any of the Level 3A Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td>A biomedical condition has arisen, or an identified biomedical problem is being addressed which is not responding to treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td>The client’s emotional or behavioral problems have diminished in acuity to the extent that availability of 24-hr medical, psychosocial, and/or nursing monitoring on a daily basis is no longer necessary, and the client does not meet any of the Level 3A Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td>A psychiatric, emotional, or behavioral condition exists that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>
| 4. Treatment Acceptance/Resistance | **Discharge:**
The client’s awareness and acceptance of an addiction problem and commitment to definitive treatment is sufficient to expect treatment compliance in an appropriate type of service as evidenced by:

1. The client is able to recognize the severity of his/her drug or alcohol problem,
2. The client understands his/her self-defeating relationship with drugs and alcohol,
3. The client accepts the concepts of continued care and has participated in the development of a post-detoxification treatment plan, AND
4. The client does not meet any of the Level 3A Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
The client does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment in this level of care. However, the client meets the Admission criteria for another type of service.

| 5. Relapse Potential | N/A |

| 6. Recovery Environment | **Discharge:**
Clients must meet ONE of the following:

A. Problem areas in the client’s social and interpersonal environment are responding to treatment, and the environment is now sufficiently supportive of recovery to allow discharge or transfer to a less intensive level of care, and the client does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment in this or other Level 3A dimensions;

B. The social and interpersonal environment has not changed or has deteriorated, but the client has learned skills to cope with the current situation, or has secured an alternative environment, and does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment at this or other Level 3A dimensions.

**Referral:**
Clients must meet ONE of the following:

A. The social and interpersonal environment has deteriorated, and the client has not learned the necessary coping skills for the deteriorating situation. An extended care alternative environment has been found, but the client is unwilling to be transferred, and he/she does not meet any of the Level 3A Continued Stay criteria that indicate the need for further treatment in this or other Level 3A Dimensions;

B. The client meets the Admission criteria for another type of service.
Level 3B
Medically Monitored Short Term Residential

Description of Service Level

- Medically Monitored Short Term Residential treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment for addicted clients in acute distress. These clients’ addiction symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a key treatment goal.

- This treatment is conducted at a Pennsylvania Department of Health licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or a health care-specific environment.

- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio is not to exceed 8:1 during primary care hours.

Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Emergency medical services available
- Referral to detoxification, if clinically needed
- Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed
- Biopsychosocial Assessment
- Individualized treatment planning, with reviews at least every 30 days (where treatment is less than 30 days, review shall occur every 15 days)
- Individual therapy
- Group therapy (group size: no more than 12 members)
- Marital therapy (if appropriate)
- Family therapy (if appropriate)
- Access to occupational and vocational counseling
- Monitoring of medication, if necessary
- Physical exam
- Development of discharge plan and plan for referral into continuum of care
• Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)

**Recommended Services and Support Systems include:**

• Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs

• Availability of conjoint treatment

• Collaboration between the treatment team and various agencies for the coordinated provision of services

The **Required Staff** in Medically Monitored Short Term Residential treatment include a **director** and **counselor(s)**, and a **clinical supervisor** for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The **Staff who may be Recommended** may include a **clinical supervisor** or **lead counselor**, **social services counselor**, a **psychiatrist**, a **psychologist**, a **medical consultant**, and any other health and human services staff or consultants (i.e. **addiction counselors** or other **certified addiction clinicians**) who may more effectively serve the facility’s population.
### Level 3B (Medically Monitored Short Term Residential)

#### Admission Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet, at a minimum, Level 3B criteria for Dimension 3, and Level 3B criteria from one of Dimensions 4, 5, and 6. Clients cannot meet criteria in Dimension 1 higher than Level 3B. If the client exceeds Level 3B Dimension 1 criteria, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Acute Intoxication or Withdrawal</th>
<th>Clients must meet all of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR</td>
<td></td>
</tr>
<tr>
<td>2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR</td>
<td></td>
</tr>
<tr>
<td>3. Sub-acute symptoms of protracted withdrawal which, if present, can be managed safely without daily medically managed intervention.</td>
<td></td>
</tr>
<tr>
<td>B. For clients with withdrawal symptoms no more severe than those noted in Section A, the client has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial interview session.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Biomedical Conditions and Complications</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Continued alcohol/drug use places client in possible danger of serious damage to physical health for any concomitant biomedical conditions (e.g. continued use of alcohol despite diagnosis and/or history of diabetes, cirrhosis of the liver, pancreatitis or seizures during withdrawal, continued cocaine use despite history of seizures associated with such use, high blood pressure or cardiovascular or cardiac problems, or continued alcohol/drug use within a self-destructive lifestyle while HIV-positive or AIDS-symptomatic);</td>
<td></td>
</tr>
<tr>
<td>B. Biomedical complications of addiction or concurrent biomedical illness require medical monitoring but not intensive care (e.g. AIDS-symptomatic);</td>
<td></td>
</tr>
<tr>
<td>C. If client is pregnant, continued or recurring alcohol/drug use would place the fetus in imminent danger of temporary or permanent disability;</td>
<td></td>
</tr>
<tr>
<td>D. The client’s biomedical complications are not severe enough for Levels 3 or 4, but are sufficient to distract from recovery efforts. Such conditions, which require medical monitoring, could be treated by a concurrent arrangement with another treatment provider.</td>
<td></td>
</tr>
</tbody>
</table>
### 3. Emotional/Behavioral Conditions and Complications

Clients must meet ONE of the following:

A. Depression and/or other emotional/behavioral symptoms (e.g. compulsive behaviors) are sufficiently interfering with abstinence, recovery, and stability to the degree that a structured 24-hr environment is need to address recovery efforts;

B. There is a moderate risk (usually manifested by highly dysfunctional behavior in the recent past) of behaviors endangering self or others (e.g. suicidal or homicidal thoughts with no active plan, but a history of suicidal gestures or homicidal threats);

C. The client is manifesting stress behaviors related to recent or threatened losses in the work, family, or social arenas, to the extent that activities of daily living are significantly impaired. A 24-hr structured secure environment is needed to help the client address his/her addiction;

D. There is a history or presence of violent or disruptive behavior during intoxication, with imminent danger to self or others;

E. Concomitant personality disorders (e.g. antisocial personality disorder with verbal aggressive behavior requiring constant limit-setting) are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.

### 4. Treatment Acceptance/Resistance

Despite serious consequences and/or effects of the addiction on the client’s life (e.g. health, family, work, or social problems), the client does not accept or relate to the severity of these problems. The client is in need of intensive motivating strategies, activities, and processes only available within a 24-hr program.

### 5. Relapse Potential

Clients must meet ONE of the following:

A. Despite a history of treatment episodes at a less intensive level of care, the client is experiencing an acute crisis with a concomitant intensification of addiction symptoms (e.g. difficulty postponing gratification and related drug-seeking behavior);

B. The client is assessed to be in danger of drinking or drugging with attendant severe consequences, and is in need of 24-hr short-term professionally directed clinical interventions;

C. The client recognizes that alcohol and/or drug use is excessive and has attempted to reduce or control it, but has been unable to do so as long as alcohol and/or drugs are present in his/her immediate environment.
<table>
<thead>
<tr>
<th>6. Recovery Environment</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. The client lives in an environment (e.g. social or interpersonal network) in which treatment is unlikely to succeed (e.g. family full of interpersonal conflict which undermines client’s efforts to change, family members or significant others living with the client who manifest current substance abuse problems and are likely to undermine the client’s recovery);</td>
</tr>
<tr>
<td></td>
<td>B. Logistic impediments (e.g. distance from treatment facility, mobility limitations, lack of driver’s license, etc.) preclude participation in treatment services at a less intensive level;</td>
</tr>
<tr>
<td></td>
<td>C. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the client’s current environment which will make recovery unlikely without removing the individual from this environment;</td>
</tr>
<tr>
<td></td>
<td>D. The client is engaged in an ongoing activity (e.g. criminal activity to support habit) or occupation where continued alcohol and/or drug use on the part of the client constitutes substantial imminent risk to public or personal safety (e.g. client is airline pilot, bus driver, police officer, member of clergy, doctor, nurse, construction worker, etc.).</td>
</tr>
</tbody>
</table>
# Level 3B (Medically Monitored Short Term Residential)
## Continued Stay Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td></td>
<td>A. Acute symptoms of intoxication/withdrawal are absent in the client;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. The client exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention and are not severe enough to interfere with participation in treatment;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. The client presents symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D. The client reports a limited lapse of sobriety that can be addressed constructively.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td></td>
<td>A. Concomitant biomedical problems exacerbated by client’s chemical abuse problems continue to diminish but are not sufficiently resolved to allow transfer to another level of care;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. The client has begun to absorb education specific to the negative interaction of substance abuse and his/her medical condition, but still needs frequent reinforcement, and is moving towards improved care of physical self (if pregnant, physical selves of client and fetus), but still has occasional lapses.</td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td></td>
<td>A. The client is making progress toward resolution of an emotional/behavioral problem (e.g. stress, violent behaviors, or verbal aggressive behaviors which require constant limit-setting), but he/she has not sufficiently resolved problems to allow transfer or discharge to a more appropriate level of care;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. The client is being held pending transfer (within 48 hours) to a more intensive inpatient service.</td>
</tr>
<tr>
<td>4. Treatment Acceptance/Resistance</td>
<td></td>
<td>The client recognizes the severity of the alcohol and/or drug problems, but demonstrates minimal understanding of his/her self-defeating use of alcohol/drugs; the client is, nonetheless, progressing in treatment.</td>
</tr>
</tbody>
</table>
| 5. Relapse Potential | Clients must meet ONE of the following:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The client continues to exhibit intensive addiction symptomatology (e.g. persistent drug or alcohol craving);</td>
<td></td>
</tr>
<tr>
<td>B. The client recognizes the severity of his or her relapse triggers and dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills needed to maintain abstinence; the client is, nonetheless, progressing in treatment.</td>
<td></td>
</tr>
</tbody>
</table>

| 6. Recovery Environment | Clients must meet ONE of the following:
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Problem aspects of the client’s social and interpersonal life are responding to treatment, but are not sufficiently supportive of recovery to allow discharge or transfer to a less intensive level of care;</td>
<td></td>
</tr>
<tr>
<td>B. The social and interpersonal life of the client have not changed or have deteriorated, and the client needs additional treatment to learn to cope with the current situation or take steps to secure an adaptive environment;</td>
<td></td>
</tr>
<tr>
<td>C. The environment from which the client came still poses a danger to him/her for physical, sexual, and/or severe emotional attack or victimization.</td>
<td></td>
</tr>
</tbody>
</table>
## Level 3B (Medically Monitored Short Term Residential)
### Discharge/Referral Criteria across 6 Dimensions

**Dimensional Scoring Specifications**
Clients must meet Level 3B criteria for all six dimensions.

<table>
<thead>
<tr>
<th>Dimensional Area</th>
<th>Discharge</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td><strong>Discharge:</strong> Clients must meet all of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is assessed as not being in intoxication or withdrawal,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. He/she does not manifest symptoms of protracted withdrawal syndrome,</td>
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<tr>
<td></td>
<td>C. He/she does not meet any of the Level 3B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
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</tr>
<tr>
<td></td>
<td><strong>Referral:</strong> Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is abusing alcohol or drugs and meets the Admission criteria for a more intensive type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. The client does not meet any of the Level 3B Continued Stay criteria, but does meet the Admission criteria for a lesser type of service.</td>
<td></td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td><strong>Discharge:</strong> Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Client’s biomedical problems, if any, have diminished or stabilized to the extent that the availability of medical and/or nursing monitoring is no longer necessary, and the client does not meet any of the Level 3B Continued Stay criteria OR the Admission criteria for any other type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Client demonstrates the understanding and the skills necessary to manage any biomedical conditions without medical monitoring. If pregnant, the client demonstrates the skills necessary to protect herself and her fetus from harm.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral:</strong> There is a biomedical condition that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
<td></td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td><strong>Discharge:</strong> The client’s emotional/behavioral problems (e.g. depression, stress, compulsive behaviors, violence) have diminished in acuity to the extent that 24-hr medical, psychosocial, and/or nursing monitoring is no longer necessary, and the client does not meet any of the Level 3B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Referral:</strong> Clients must meet ONE of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Client has attained a sufficient degree of recovery skills to warrant transfer, and he/she meets the Admission criteria for a lesser type of service;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service.</td>
<td></td>
</tr>
</tbody>
</table>
### 4. Treatment Acceptance/Resistance

**Discharge:**
Client’s awareness and acceptance of an addiction problem and commitment to definitive treatment are sufficient to expect treatment compliance in a less intensive type of service, as evidenced by:

1. The client is able to recognize the severity of his/her alcohol/drug problem,
2. The client understands his/her self-defeating relationship with alcohol/drugs and understands his/her triggers and dysfunctional behaviors which lead to alcohol/drug use,
3. The client accepts the concepts of continuing care and has participated in the development of a post-treatment recovery plan, AND
4. The client does not meet any of the Level 3B Continued Stay criteria OR the Admission criteria for any other type of service.

**Referral:**
Clients must meet ONE of the following:

A. The client has failed to achieve essential treatment objectives of the treatment plan to the degree that no further progress is likely to occur at this level of care; however, the client meets the Admission criteria for another type of service;

B. The client meets the Admission criteria for another type of service.

### 5. Relapse Potential

**Discharge:**
Clients must meet ONE of the following:

A. The client is capable of following and completing a specific continuing care recovery plan. The client’s integration of therapeutic gains is established sufficiently that the client does not appear at risk of imminent relapse, and the client does not meet any of the Level 3B Continued Stay criteria indicating the need for further treatment in this or other Level 3B dimensions;

B. The client demonstrates skills necessary to interrupt behaviors that may jeopardize his/her recovery and is able to apply appropriate actions to interrupt these behaviors and therefore maintain ongoing abstinence.

**Referral:**
Clients must meet ONE of the following:

A. The client is experiencing an intensification of addiction symptomatology (e.g. craving, return to regular use of psychoactive substances) despite continued interventions, to the extent that he/she requires a more intensive level of care;

B. The client meets the Admission criteria for another type of service.
<table>
<thead>
<tr>
<th>6. Recovery Environment</th>
<th>Discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. Problem aspects of the client’s social and interpersonal environment are responding to treatment, and the environment is now sufficiently supportive of recovery to allow discharge or transfer to a less intensive level of care, and the client does not meet any of the Level 3B Continued Stay criteria that indicate the need for further treatment in this or other Level 3B dimensions;</td>
</tr>
<tr>
<td></td>
<td>B. The social and interpersonal environments have not changed or have deteriorated, but the client has learned skills to cope with the current situation, or has secured an alternative environment, and does not meet any of the Level 3B Continued Stay criteria that indicate the need for further treatment in this or other Level 3B dimensions.</td>
</tr>
<tr>
<td>Referral:</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The social and interpersonal environments have deteriorated and the client has not learned the skills necessary to cope with the deteriorating situation. An extended care alternative environment has been found, but the client is unwilling to be transferred, and he/she does not meet any of the Level 3B Continued Stay criteria that indicate the need for further treatment in this or other Level 3B dimensions;</td>
</tr>
<tr>
<td></td>
<td>B. The client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>
Level 3C
Medically Monitored Long Term Residential

Description of Service Level

- Medically Monitored Long Term Residential treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment for addicted clients in chronic distress, whose addiction symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. **Habilitation is the treatment goal.** These programs serve clients with chronic deficits in social, educational, and economic skills, impaired personality and interpersonal skills, and significant drug-abusing histories which often include criminal lifestyles and subcultures. These individuals need a model more accurately described as habilitation, as opposed to the rehabilitation model. This service often requires global changes in lifestyle, such as abstinence from mood-altering chemicals (other than those needed to treat illnesses), elimination of antisocial activity, a new outlook regarding employment, and the development, display, and integration of positive social attitudes and values.

- This treatment is conducted in a Pennsylvania Department of Health licensed drug and alcohol residential non-hospital treatment and rehabilitation facility located in a freestanding or health care-specific environment.

- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FTE Counselor ratio must not exceed 8:1 during primary care hours.

Required Services and Support Systems include:
- Regular, scheduled psychotherapy
- Biopsychosocial Assessment
- Specialized professional/medical consultation, and testing such as a psychiatric evaluation, HIV and TB tests, and other laboratory work, as needed
- Individualized treatment planning, with reviews at least every 30 days
- Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, medical and dental care, general health education (especially AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational and social activities (e.g. fitness, games, peer interaction)
- Monitoring of medication, as needed

- 24-hour observation, monitoring, and treatment
• Emergency medical services available
• Referral to detoxification, if clinically necessary
• Individual therapy
• Marital therapy (if appropriate)
• Family therapy (if appropriate)
• Physical exam (within 48 hours expected, but no later than 7 days)
• Development of discharge plan and plan for referral into continuum of care

Recommended Services and Support Systems include:
• Group therapy 3 times per week for at least 1.5 hours per session (group size: no more than 12)
• Individual therapy 2 times per month, for at least 1 hour per session
• Peer groups 4 times per week, for at least 45 minutes per session, to focus on daily living
• Educational/instructional groups 1 time per month

The Required Staff in Medically Monitored Long Term Residential treatment include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and the client profile, a single individual may hold one or more of the above positions.

The Staff who may be Recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. addiction counselors or other certified addiction clinicians) who may more effectively serve the facility’s population.
### Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 3C criteria for Dimension 3, and must not meet criteria higher than Level 3C for the remaining dimensions. If the client exceeds Level 3C’s Dimension 1 criteria, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet, at a minimum, Level 3C criteria for Dimension 3, and must not meet criteria higher than Level 3C for the remaining dimensions. If the client exceeds Level 3C’s Dimension 1 criteria, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.</td>
</tr>
</tbody>
</table>

#### 1. Acute Intoxication or Withdrawal

Clients must meet all of the following:

A. The client is assessed as being at minimal or no risk of severe withdrawal syndrome as evidenced by:
   1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR
   2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR
   3. Sub-acute symptoms of protracted withdrawal which, if present, can be managed safely without daily medically managed intervention.

B. For clients with withdrawal symptoms no more severe than those noted in Section A, the client has, and responds positively to, emotional support and comfort as evidenced by decreased emotional symptoms by the end of the initial treatment session, and ONE of the following:
   1. Some psychological or emotional/behavioral craving symptoms which require continued counseling and/or monitoring on a 24-hr basis, without requiring detox;
   2. Minimal withdrawal risk which is manageable at this level because of the extended time frame of treatment;
   3. Need for management of significant, severe post-acute withdrawal symptomatology (e.g. high behavioral and social urges to use, obsessions and compulsions characteristic of those coming off excessive IV drug, cocaine, or amphetamine addiction);
   4. Post-withdrawal organicity (e.g. poor immediate and/or recent memory recall) inhibits cognitive functioning, but client’s history indicates that cognition should clear sufficiently to allow client to respond to long term treatment.

#### 2. Biomedical Conditions and Complications

Clients must meet ONE of the following:

A. Continued alcohol/drug use places the client in danger of serious damage to physical health for any concomitant biomedical conditions (e.g. continued use of alcohol despite diagnosis and/or history of diabetes, cirrhosis of the liver, pancreatitis, or seizures during withdrawal, or history of cocaine use despite history of seizures with use of cocaine, high blood pressure, or cardiovascular or cardiac problems, or continued use of alcohol/drugs within a self-destructive lifestyle while HIV-positive or AIDS-symptomatic);

B. Biomedical complications of addiction or a concurrent biomedical illness requires medical monitoring but not intensive care (e.g. AIDS-symptomatic);

C. If client is pregnant, continued or resumed alcohol/drug use would place the fetus in imminent danger of temporary or permanent disability;

D. The client’s biomedical complications are not severe enough for Level 3A or 3B or Level 4, but are sufficient to distract from recovery efforts. Such conditions, which require medical monitoring, could be provided by a concurrent arrangement with another treatment provider.
3. Emotional/Behavioral Conditions and Complications

Clients must meet at least 2 of the following:

A. Disordered Living Skills:
   1. Lacking socially acceptable norms and/or coping skills on an interpersonal, vocational, educational, or financial management level; OR
   2. A history of inability or unwillingness to internalize a sense of social responsibility; OR
   3. A history of significant consistent substance abuse prior to early adolescence which has continued into adulthood and has led to emotional immaturity as evidenced by magical thinking, impulsive behavior, and severe emotional sensitivity.

B. Disordered Social Adaptiveness:
   1. A history of repetitive antisocial behavior patterns or various criminal charges or behavior that has or could have led to incarceration or probation; OR
   2. A history of rebellion and/or denigration of acceptable parental and/or societal values leading to a disregard of authority and basic rules which make it unlikely that a less structured level of care is appropriate.

C. Disordered Self Adaptiveness:
   1. Persecutory fear, or a poor sense of self-worth as evidenced by feelings of chronic rejection, loneliness, or alienation; OR
   2. Having a history of a deeply ingrained sense of personal unworthiness or self-hatred evidenced by defeating and denigrating behaviors; OR
   3. A history of chronic external focus and/or seeking external stimuli to the exclusion of developing internal supports, as possibly evidenced by multiple addictions; OR
   4. Inability to form supportive relationships, difficulty or unwillingness to disclose feelings; OR
   5. Pronounced external locus of control as evidenced by blaming others for personal circumstances, and unwillingness or inability to make decisions and choices to effect positive changes in the circumstances that the client regards as undesirable.

D. Disordered Psychological Status:
   1. A history of early onset (e.g. pre-adolescence) of emotional blunting or impairment, or developmental disorders as exemplified by: lack of geographical roots, lack of healthy role-modeling opportunities, little or no opportunity for parental bonding or guidance, a pervasive history of parental enabling, gang membership, dysfunctional parental modeling (such as long-term criminal behavior or other antisocial lifestyles) OR
   2. A history of significant impulsivity without due regard for potential negative consequences.

4. Treatment Acceptance/Resistance

Clients must meet ONE of the following:

A. Despite serious consequences and/or effects of addiction on client’s life (e.g. health, family, work, or social problems), he/she does not accept or relate to the severity of these problems. Therefore, the client is in need of intensive motivating strategies, activities, and processes only available in a 24-hr structured environment;

B. A high resistance to treatment despite negative consequences based on lack of living skills, education, self-discipline, or therapeutic resolution of psychological or psychosocial trauma.
### 5. Relapse Potential

Clients must meet ONE of the following:

A. A history of one or more treatment episodes at a less intensive level of care. Client is experiencing an acute crisis with a concomitant intensification of addiction symptoms (e.g. difficulty postponing immediate gratification or related drug-seeking behavior);

B. Client is assessed to be in danger of drinking or drugging with attendant severe consequences, and is in need of 24-hr professionally directed clinical interventions;

C. Client recognizes that alcohol/drug use is excessive and has attempted to reduce or control it, but has been unable to do so as long as alcohol/drugs are present in his/her immediate environment.

### 6. Recovery Environment

Clients must meet ONE of the following:

A. Client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g. family full of interpersonal conflict which undermines client’s efforts to change, or family members and/or significant others living with client who currently manifest substance use disorders and are likely to undermine the client’s recovery);

B. Logistic impediments (e.g. distance from the treatment facility, limited mobility, lack of driver’s license) preclude participation in treatment services at a less intensive level;

C. There is a danger of physical, sexual, and/or severe emotional attack or victimization in the client’s current environment which will make recovery unlikely without removing the individual from this environment;

D. Client is engaged in ongoing activity (e.g. criminal activity to support habit) or occupation where continued drug/alcohol use constitutes substantial imminent risk to public or personal safety (e.g. client is airline pilot, bus driver, police officer, clergy member, doctor, construction worker, etc.).
### Dimensional Scoring Specifications

Clients must meet, at a minimum, Level 3C criteria for Dimensions 3, 4 and 5, and no criteria higher than Level 3C for the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Acute Intoxication or Withdrawal</strong></td>
</tr>
<tr>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td>A. Acute symptoms of intoxication/withdrawal are absent in the client;</td>
</tr>
<tr>
<td>B. Client exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention, and are not severe enough to interfere with participation in treatment;</td>
</tr>
<tr>
<td>C. Client exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;</td>
</tr>
<tr>
<td>D. Client continues to have some psychological/emotional/behavioral craving, but frequency of occurrence is beginning to diminish;</td>
</tr>
<tr>
<td>E. Post-acute symptomatology (e.g. behavioral or social urges to use) or obsessions/compulsions typical of drug-specific sequences are less intrusive but still powerful on occasion;</td>
</tr>
<tr>
<td>F. Post-withdrawal organicity (e.g. poor immediate and/or recent memory recall) is abating but not gone.</td>
</tr>
</tbody>
</table>

| **2. Biomedical Conditions and Complications** |
| Clients must meet ONE of the following: |
| A. Concomitant biomedical problems exacerbated by client’s chemical abuse continue to diminish, but are not sufficiently resolved to allow transfer to another level of care; |
| B. Client has begun to absorb education specific to the negative interaction of substance abuse and his/her medical condition, but still needs frequent reinforcement; client is moving toward improved care of physical self (and of fetus, if pregnant) but still has occasional lapses; |
| C. Client is responding to treatment aid, and the biomedical conditions and problems continue not to be severe enough to warrant a higher level of care. |

### Level 3C (Medically Monitored Long Term Residential)

**Continued Stay Criteria across 6 Dimensions**
### 3. Emotional/Behavioral Conditions and Complications

Clients must meet at least 2 of the following:

**A. Disordered Living Skills:**
1. Client is in the process of unlearning old norms and integrating new ones; however, the integration is not yet intact and automatic. Occasional lapses from habilitative efforts still occur and keep client at risk; OR
2. Client is developing a sense of constructive community integration and involvement, and has increased his/her desire to internalize these skills, but acting-out limit-setting confrontations are still necessary on occasion; OR
3. Client has begun to realize that abuse issues must be dealt with so that recovery can proceed. Client continues to react with shame, rage, revenge, or isolation on occasion in his/her struggle for resolution; OR
4. Because of early adolescent onset of substance abuse, client lacks developmental maturity; client’s skills in these areas are still in formative stage, and he/she continues to require major daily clinical guidance to reinforce these new skills.

**B. Disordered Social Adaptiveness:**
1. Client continues to have difficulty in assimilating concepts of responsiveness to society; OR
2. Client has begun to understand rebellion as a dysfunctional self-defeating process, but has not yet accepted the need for compliance with rules, societal mores, or external direction. Defenses are not always identified as such, and client continues to need intensive daily therapy to recognize these behaviors when they occur; OR
3. Inappropriate denigration, devaluation, or dominance issues are being addressed, but client’s defenses are still partially intact. He/she has not yet grasped the concept of the healthy boundaries needed to validate his/her own sense of worth and also the worth of others; OR
4. Client has not yet internalized skills nor begun to implement them.

**C. Disordered Self Adaptiveness:**
1. Fears are beginning to diminish, and/or concepts of self and societal acceptance are not yet firm enough to avoid regression to old patterns; OR
2. Sense of self-validation and individuation not yet secure; OR
3. Acceptance of self-worth and raising of self-esteem have not yet been sufficiently integrated; OR
4. Client is demonstrating some progress in his/her ability to form supportive relationships and appropriately disclose feelings; however, he/she still cannot adequately achieve these outcomes in a manner which could support recovery.

**D. Disordered Psychological Status:**
1. Client’s recognition of his/her dysfunctional past has not yet been absorbed. The relearning and trusting process needed to supplant his/her chaotic world view has not yet been integrated; OR
2. Client’s ability to experience self-appreciation and defer gratification is still undeveloped; client has difficulty processing cause and effect.

### 4. Treatment Acceptance/Resistance

Clients must meet ONE of the following:

**A.** The client recognizes the severity of the alcohol/drug problem, but demonstrates minimal understanding of his/her self-defeating use of alcohol/drugs; nevertheless, the client is progressing in treatment;

**B.** The client recognizes the severity of his/her alcohol/drug problem and exhibits understanding of his/her personal relationship with psychoactive substances, yet does not demonstrate that he/she has assumed the responsibility necessary to cope with the problem.
| 5. **Relapse Potential** | Clients must meet ONE of the following:

A. Client continues to exhibit intensive addiction symptomatology (e.g. persistent drug/alcohol craving);

B. Client recognizes specific relapse triggers or dysfunctional behaviors which have previously undermined sobriety; however, he/she demonstrates minimal understanding of their role in relapse; client is nevertheless progressing in treatment;

C. Client recognizes the severity of his/her relapse triggers and dysfunctional behaviors which undermine sobriety, and manifests an understanding of these dysfunctional behaviors, yet does not demonstrate the skills necessary to interrupt these behaviors and apply alternative coping skills needed to maintain ongoing abstinence. |

| 6. **Recovery Environment** | Clients must meet ONE of the following:

A. Problem aspects of the client’s social and interpersonal life are responding to treatment, but are not sufficiently supportive of recovery to allow discharge or transfer to a less intensive level of care;

B. The social and interpersonal life of the client has not changed or has deteriorated, and the client needs additional treatment to learn to cope with the current situation or to take steps to secure an alternative environment;

C. Client has not yet given up emotional ties to his/her past antisocial behaviors, and is unable to commit to an acceptable, responsible, or productive way of life. |
## Level 3C (Medically Monitored Long Term Residential) Discharge/Referral Criteria across 6 Dimensions

### Dimensional Scoring Specifications
Clients must meet Level 3C criteria for all six dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Discharge</th>
<th>Referral</th>
</tr>
</thead>
</table>
| **1. Acute Intoxication or Withdrawal** | A. The client is assessed as not being in intoxication or withdrawal,  
B. The client does not manifest symptoms of protracted withdrawal syndrome, and  
C. The client does not meet any of the Level 3C Continued Stay criteria OR the Admission criteria for any other type of service. | A. The client meets the Admission criteria for a more intensive type of service;  
B. Post-withdrawal organicity has abated and/or can be managed at a less intensive type of service and the client demonstrates the skills necessary to compensate or adjust;  
C. Post-withdrawal organicity has escalated and/or cannot be managed at this type of service; medical evaluation and referral required. |
| **2. Biomedical Conditions and Complications** | A. Client’s biomedical problems, if any, have diminished or stabilized to the extent that the availability of medical and/or nursing monitoring is no longer necessary, and the client does not meet any of the Level 3C Continued Stay criteria OR the Admission criteria for any other type of service;  
B. Client demonstrates understanding and the skills necessary to manage any biomedical conditions without medical monitoring; if pregnant, client demonstrates the skills necessary to protect herself and her fetus from harm. | There is a biomedical condition that is interfering with addiction treatment, and the client meets the Admission criteria for another type of service. |
### Discharge:

Clients must meet at least 2 of the following:

**A. Disordered Living Skills:**
1. Client has progressed to the point where new norms are integrated and demonstrated in daily living; OR
2. Client has developed a sense of constructive community integration and involvement, as far as generally accepted societal roles are concerned; OR
3. Client has resolved identified abuse issues sufficiently enough to be transferred to a lower level of care; OR
4. Client has internalized skills and demonstrated mature behaviors to make immediate or short-term relapse unlikely.

**B. Disordered Social Adaptiveness:**
1. Client has now assimilated and committed himself/herself to responsible, generally accepted, legal, licit, and moral behaviors; OR
2. Client has rejected rebelliousness as a coping strategy; OR
3. Client has developed a strong sense of self and understands the rights of others, and does not display tendencies toward denigration, devaluation, or dominance of others; OR
4. Client has developed an achievable life plan, and is willing and capable of continuing the work of developing goals and working toward their fruition.

**C. Disordered Self Adaptiveness:**
1. Client has developed successful strategies for handling fear, feelings of rejection, loneliness, and alienation, and has demonstrated the skills needed to implement these strategies; OR
2. Client has an understanding of his/her self-worth, and no longer participates in self-denigrating thoughts or behaviors; OR
3. Client has established a sufficient internal support to balance the need for external stimulation; OR
4. Client has demonstrated the ability to form supportive relationships, and appropriately discloses feelings in a manner which supports recovery.

**D. Disordered Psychological Status:**
1. Client has successfully addressed early onset emotional impairment and/or developmental disordering. Dysfunctional symptomatology has been reduced to generally acceptable thresholds; OR
2. Client realizes impulsive behaviors have led to long-term difficulties, and can now identify these urges and implement strategies to control them.

### Referral:

Clients must meet ONE of the following:

**A.** A psychiatric/emotional/behavioral condition exists that is interfering with addiction treatment;

**B.** Client meets the Admission criteria for another type of service.
| 4. Treatment Acceptance/Resistance | **Discharge:**  
Clients must meet all of the following:  
A. The client’s awareness and acceptance of an addiction problem and commitment to definitive treatment are sufficient to expect treatment compliance in a less intensive type of service, as evidenced by:  
   1. Client is able to recognize the severity of his/her alcohol/drug problem, AND  
   2. Client understands his/her self-defeating relationship with alcohol/drugs and understands his/her triggers and dysfunctional behaviors which lead to alcohol/drug use, AND  
   3. Client accepts the concepts of continued care, and has participated in the development of a post-treatment recovery plan.  
B. The client also does not meet any of the Level 3C Continued Stay criteria OR the Admission criteria for any other type of service.  

**Referral:**  
Clients must meet ONE of the following:  
A. The client has failed to achieve essential treatment objectives to the degree that no further progress is likely to occur at this level of care; however, the client meets the Admission criteria for another type of service;  
B. The client meets the Admission criteria for another type of service. |
|---|---|
| 5. Relapse Potential | **Discharge:**  
Clients must meet ONE of the following:  
A. Client is capable of following and completing a specific continuing care recovery plan. His/her integration of therapeutic gains is sufficiently established that he/she does not appear to be at risk of imminent relapse; the client also does not meet any of the Level 3C Continued Stay criteria for further treatment on any dimension in this level;  
B. Client demonstrates the ability to manage relapse triggers.  

**Referral:**  
Clients must meet ONE of the following:  
A. Client is experiencing an intensification of addiction symptomatology (e.g. craving, or return to regular use of psychoactive substances), despite continued interventions, to the extent that he/she requires a more intensive level of care;  
B. Client meets the Admission criteria for another type of service. |
### 6. Recovery Environment

**Discharge:**
Clients must meet ONE of the following:

A. Problem aspects of the client’s social and interpersonal environment are responding to treatment, and the environment is sufficiently supportive of recovery to allow discharge to a less intensive level of care, and the client does not meet any of the Level 3C Continued Stay criteria for further treatment on any dimension in this level;

B. The social and interpersonal environment has not changed or has deteriorated, but the client has learned skills to cope with the current situation, or has secured an alternative environment, and does not meet any of the Level 3C Continued Stay criteria for further treatment on any dimension in this level.

**Referral:**
Clients must meet ONE of the following:

A. The social and interpersonal environment has deteriorated, and the client has not learned the skills necessary to cope with the deteriorating situation. An extended care alternative environment has been found, but the client is unwilling to be transferred. Further, the client does not meet any of the Level 3C Continued Stay criteria for further treatment on any dimension in this level;

B. Client meets Admission criteria for another type of service.
Level 4A
Medically Managed Inpatient Detoxification

Description of Service Level

- Medically Managed Inpatient Detoxification is a type of treatment which provides 24-hour medically directed evaluation and detoxification of psychoactive substance use disordered clients in an acute care setting. Detoxification is the process whereby a drug- or alcohol-intoxicated or dependent client is assisted through the period of time needed to eliminate (by metabolic or other means) the presence of the intoxicating substance or the dependency factors, while keeping the physiological or psychological risk to the client at a minimum. Ideally, this process should also include efforts to motivate and support the client to seek formal treatment after the detoxification process. The clients who utilize this type of care have acute withdrawal problems (with or without biomedical and/or emotional/behavioral problems) which are severe enough to require primary medical and nursing care facilities. 24-hour medical service is provided, and the full resources of the hospital facility are available. Although this treatment is specific to psychoactive substance use disorder, the multi-disciplinary team and the availability of support services allows for the conjoint treatment of coexisting acute biomedical and/or emotional/behavioral conditions which could jeopardize recovery and need to be addressed.

- This type of treatment is conducted at a Pennsylvania Department of Health licensed acute care setting, with intensive biomedical and/or psychiatric services and a certified addiction treatment unit. Three examples of such settings are: an acute care general hospital, an acute care psychiatric hospital or a psychiatric unit in an acute care general hospital, or an appropriately licensed chemical dependency specialty hospital with an acute care medical and nursing staff and emergency and life-support equipment. Such settings must be capable of providing medically directed acute detoxification and related treatments aimed at alleviating acute emotional, behavioral, and/or biomedical stress resulting from the client’s use of alcohol or other drugs. If needed, life support care and treatment is available on-site, or through an effective arrangement, for the timely and responsive provision of such care. This may be accomplished through the transfer of the client to another service within the facility or to another medical facility.

- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FT Primary Care Staff Person (e.g. Physician’s Assistant, RN, LPN, clinical staff) ratio is not to exceed 5:1 during primary care hours.
Required Services and Support Systems include:

- Assessment and treatment of adult clients with psychoactive substance use disorders or addicted clients with concomitant acute biomedical and/or emotional/behavioral disorders. Clinicians in this setting must be knowledgeable about the biopsychosocial dimensions of addictions, biomedical problems, and emotional/behavioral disorders.

- 24-hour physician availability

- 24-hour primary nursing care and observation

- Professional therapeutic services

- Referral agreements among different levels of care

- Biopsychosocial Assessment

- Monitoring of medication, as needed

- Health care education services

- Services for families and significant others

- Medication administered in accordance with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures

- Comprehensive nursing exam upon admission

- Physician-approved admission

- Physician who is responsible for a comprehensive history (including drug and alcohol) and a physical examination within 24 hours following admission

- Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because this population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of clients found to have such illnesses, so as to protect other clients and staff from acquiring these diseases.

The **Required Staff** in a Medically Managed Inpatient Detox facility is chosen according to the Joint Commission on the Accreditation of Hospital Organization’s (JCAHO’s) standard hospital practices. In addition, they must comply with the PA Department of Health’s staffing requirements.

The **Staff who may be Recommended** may include trained clinicians, addiction counselors, or registered, certified addiction clinicians able to administer planned interventions according to the assessed addiction needs of the client.
Level 4A (Medically Managed Inpatient Detox)
Admission Criteria across 6 Dimensions

**Dimensional Scoring Specifications**
Clients must meet, at a minimum, Dimension 1 criteria for Level 4A, or Dimension 1 criteria for 3A if Dimension 2 or 3 are at Level 4A.

<table>
<thead>
<tr>
<th>1. Acute Intoxication or Withdrawal</th>
<th>Clients must meet one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Client is assessed as being at risk of severe withdrawal syndrome as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) greater than or equal to 20; OR</td>
<td></td>
</tr>
<tr>
<td>2. Blood alcohol greater than 0.1gm% with withdrawal signs present; or blood alcohol greater than 0.2gm%; OR</td>
<td></td>
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<tr>
<td>3. Pulse greater than 110 or blood pressure higher than 160/110 and a CIWA-Ar score greater than 10; OR</td>
<td></td>
</tr>
<tr>
<td>4. History of seizures, hallucinations, myoclonic contractions, or delirium tremens when withdrawing from similar amounts of alcohol or other sedative hypnotic drugs; OR</td>
<td></td>
</tr>
<tr>
<td>5. Seizures, delirium tremens, hallucinations, myoclonic contractions, or hyperperxia (elevated temperature); OR</td>
<td></td>
</tr>
<tr>
<td>6. Daily ingestion of sedative hypnotics for over six months plus daily alcohol use, or regular use of another mind-altering drug, known to have its own withdrawal syndrome, with a coexisting chronic mental/physical disorder; OR</td>
<td></td>
</tr>
<tr>
<td>7. Daily ingestion of sedative hypnotics above the recommended therapeutic dosage level for at least 4 weeks, with a coexisting chronic mental/physical disorder; OR</td>
<td></td>
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<tr>
<td>8. Antagonist medication used in withdrawal (e.g. pharmacological induction of opiate withdrawal and subsequent management); OR</td>
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<tr>
<td>9. Recent (&lt;12 hrs) serious head trauma or loss of consciousness resulting in need to observe intoxicated client more closely; OR</td>
<td></td>
</tr>
<tr>
<td>10. Client with history of opioid use who exhibits Narcotic Withdrawal Scale Grade 2+ opioid withdrawal (e.g. muscular twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea, extremes of vital signs, dehydration, “curled-up position,” etc.) requiring acute nursing care for management; OR</td>
<td></td>
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<tr>
<td>11. Drug overdose compromising mental status, cardiac functioning, or other vital signs; OR</td>
<td></td>
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<tr>
<td>12. Client with history of daily opioid use for at least 2 weeks prior to admission; past attempts to stop at similar dosages have resulted in one or more signs or symptoms of withdrawal (e.g. muscular twitching, myalgia, arthralgia, abdominal pain, rapid breathing, fever, anorexia, nausea, vomiting, diarrhea); OR</td>
<td></td>
</tr>
<tr>
<td>13. Clinical state requiring close medical observation (e.g. intoxication with acute agitation or stuporous state, without reliable medical history or with history of use of substance of unknown origin, or intoxication with multiple drug combinations with unpredictable, complicated withdrawal).</td>
<td></td>
</tr>
<tr>
<td>B. There is a strong likelihood that the client will not complete detoxification or enter into continuing treatment as evidenced by current use of medication or presence of a medical condition known to interfere with ability to complete detox (e.g. MAO Inhibitors in association with alprazolam, or xanax).</td>
<td></td>
</tr>
<tr>
<td>C. This is the only available level of care which can provide the needed medical support and comfort for the client, as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>1. Detoxification regimen or client’s response to the regimen requires monitoring at least every 2 hrs (e.g. clonidine detoxification with opiates, or high dose benzodiazepine withdrawal); OR</td>
<td></td>
</tr>
<tr>
<td>2. Client requires detoxification while pregnant.</td>
<td></td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>A. Biomedical complications of addiction requiring medical management and skilled nursing care;</td>
<td></td>
</tr>
<tr>
<td>B. Concurrent biomedical illness or pregnancy needing stabilization and daily medical management with daily primary nursing interventions (e.g. severe anemia, poorly controlled or complicated diabetes mellitus);</td>
<td></td>
</tr>
<tr>
<td>C. Presence of biomedical problems requiring inpatient diagnosis and treatment (e.g. liver disease resulting in hepatic decompensation, acute pancreatitis requiring parenteral treatment, active gastrointestinal bleeding, cardiovascular disorders requiring monitoring, multiple current biomedical problems);</td>
<td></td>
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<tr>
<td>D. Recurrent or multiple seizures;</td>
<td></td>
</tr>
<tr>
<td>E. Disulfiram (Antabuse)-alcohol reaction;</td>
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<tr>
<td>F. Life-threatening symptomatology related to excessive use of alcohol/drugs (e.g. stupor, convulsions, etc.);</td>
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<tr>
<td>G. Previously diagnosed medical conditions being gravely complicated or exacerbated by chemical use;</td>
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<tr>
<td>H. Changes in client’s medical status, such as a severe worsening of medical condition, make abstinence imperative;</td>
<td></td>
</tr>
<tr>
<td>I. Client demonstrates other biomedical problems requiring 24-hr observation and evaluation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Emotional/Behavioral Conditions and Complications</th>
<th>Clients must meet ONE of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Emotional/behavioral complications of addiction require medical management and skilled nursing care;</td>
<td></td>
</tr>
<tr>
<td>B. Concurrent emotional/behavioral illness needs stabilization, daily medical management, and primary nursing interventions;</td>
<td></td>
</tr>
<tr>
<td>C. Uncontrollable behavior endangering self or others (e.g. suicidal, impulsive, aggressive, unstable, threatening, etc.);</td>
<td></td>
</tr>
<tr>
<td>D. Mental confusion or fluctuating orientation;</td>
<td></td>
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<tr>
<td>E. Coexisting serious emotional/behavioral disorders which complicate the treatment of chemical dependency and require differential diagnosis and treatment;</td>
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<tr>
<td>F. Extreme depression;</td>
<td></td>
</tr>
<tr>
<td>G. Impairment of thought processes and abstract thinking, limitations in conceptual ability impair client’s daily living activities;</td>
<td></td>
</tr>
<tr>
<td>H. Previously diagnosed psychiatric/emotional/behavioral condition being gravely complicated or exacerbated by alcohol/drug use;</td>
<td></td>
</tr>
<tr>
<td>I. Altered mental status, with or without delirium, as manifested by disorientation to self, alcoholic hallucinosis, or toxic psychosis.</td>
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<tr>
<td></td>
<td>Treatment Acceptance/ Resistance</td>
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<tr>
<td>5</td>
<td>Relapse Potential</td>
</tr>
<tr>
<td>6</td>
<td>Recovery Environment</td>
</tr>
</tbody>
</table>
Level 4A (Medically Managed Inpatient Detox)
Continued Stay Criteria across 6 Dimensions

**Dimensional Scoring Specifications**
Clients must meet, at a minimum, Level 4A criteria for Dimensions 1 and 2, and no criteria higher than Level 4A for the remaining dimensions.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication or Withdrawal</td>
<td>Persistence of acute withdrawal symptomatology, or detoxification protocol requires continued medical and/or nursing management on a 24-hr basis.</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>A biomedical condition that was initially interfering with treatment is improving, but the client still requires 24-hr continued medical management for this condition along with addiction treatment.</td>
</tr>
<tr>
<td>3. Emotional/Behavioral Conditions and Complications</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. The client is making progress toward resolution of a concomitant emotional/behavioral problem, but continued medical and nursing managed interventions are needed before transfer can be made to a less intensive level of care;</td>
</tr>
<tr>
<td></td>
<td>B. The client is being held pending transfer (within 48 hrs) to an acute psychiatric inpatient service;</td>
</tr>
<tr>
<td></td>
<td>C. The client is assessed as having a DSM Axis I psychiatric condition or disorder which, in combination with alcohol/drug use, continues to present a major mental health risk, and is actively being treated (e.g. medication stabilization).</td>
</tr>
<tr>
<td>4. Treatment Acceptance/Resistance</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Relapse Potential</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Level 4A (Medically Managed Inpatient Detox)
Discharge/Referral Criteria across 6 Dimensions

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet Level 4A criteria for Dimensions 1, 2, 3, and 4.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Acute Intoxication or Withdrawal</th>
<th>Discharge: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral:</td>
<td>Clients must meet all of the following:</td>
</tr>
<tr>
<td>A. The client is assessed as not being intoxicated or in acute alcohol/drug withdrawal, or the symptoms have diminished sufficiently to be managed in a less intensive type of service, and the client does not meet any of the Level 4A Continued Stay criteria for further treatment on any dimension in this level. Therefore, the client is to be assessed for referral to the appropriate type of service.</td>
<td></td>
</tr>
<tr>
<td>B. The client’s protracted withdrawal symptoms no longer require 24-hr management, as they are not associated with craving for the alcohol/drug, and the client does not meet any of the Level 4A Continued Stay criteria that indicate the need for further treatment on this level. Therefore, the client is to be assessed for referral to the appropriate type of service.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Biomedical Conditions and Complications</th>
<th>Discharge: Client’s biomedical problems, if any, have diminished or stabilized to the extent that daily availability of 24-hr medical and/or nursing management is no longer necessary, and he/she does not meet any of the Level 4A Continued Stay criteria OR the Admission criteria for any other type of service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral:</td>
<td>A biomedical condition has arisen, or an identified biomedical problem which is being addressed is not responding to treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Emotional/Behavioral Conditions and Complications</th>
<th>Discharge: The client’s emotional and/or behavioral problems have diminished in acuity to the extent that daily medical and nursing management is no longer necessary, and the client does not meet any of the Level 4A Continued Stay criteria OR the Admission criteria for any other type of service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral:</td>
<td>An emotional/behavioral condition has arisen, or an identified emotional/behavioral problem which is being addressed is not responding to treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>
| 4. Treatment Acceptance/Resistance | **Discharge:**  
The client's awareness of an addiction problem is sufficient to expect entry into continued addictions treatment in an appropriate type of service as evidenced by:  
1. Client is able to recognize the severity of his/her alcohol/drug problem, and  
2. Client does not meet any of the Level 4A Continued Stay criteria OR the Admission criteria for any other type of service.  
**Referral:**  
The client repeatedly refuses continued treatment despite motivating interventions, and does not meet any of the Level 4A Continued Stay criteria for further treatment on any dimension in this level. However, the client does meet the Admission criteria for another type of service. |
| 5. Relapse Potential | N/A |
| 6. Recovery Environment | N/A |
Level 4B
Medically Managed Inpatient Residential

Description of Service Level

- Medically Managed Inpatient Residential treatment provides 24-hour medically directed evaluation, care, and treatment for addicted clients with coexisting biomedical, psychiatric, and/or behavioral conditions which require frequent care. Facilities for such services need to have, at a minimum, 24-hour nursing care, 24-hour access to specialized medical care and intensive medical care, and 24-hour access to physician care.
- The setting for this type of care is a Pennsylvania Department of Health licensed acute care facility, with an intensive biomedical and/or psychiatric service contained in a Department of Health-certified hospital-based addictions rehabilitation unit.
- All employees and contracted individuals providing clinical services within the facility must comply with the PA Department of Health’s staffing requirements. The Client:FT Primary Care Staff Person (e.g. Physician’s Assistant, RN, LPN, clinical staff) ratio is not to exceed 7:1 during primary care hours. Clients who have more severe illnesses in the biomedical or emotional/behavioral dimensions will require more intensive staffing patterns and support services, such as those found in an intensive component in a hospital.

Required Services and Support Systems include:

- 24-hour observation, monitoring, and treatment
- Full resources of an acute care general or psychiatric hospital, or a medically managed intensive inpatient treatment service
- Treatment for psychoactive substance use disorder and for coexisting medical and/or psychiatric disorders
- Access to detoxification or other more intensive medical/psychiatric services for related emotional/behavioral problems or family conditions which could jeopardize recovery
- Assistance in accessing support services
- Emergency medical services available
- Referral to detox, if clinically necessary
- Specialized professional/medical consultation, and testing such as HIV and TB tests, and other laboratory work if needed
- Biopsychosocial Assessment
- Individualized treatment planning, with review at least every 30 days (where treatment is less than 30 days, the review shall occur every 15 days)
- Individual therapy

- Group therapy (group size: no larger than 12)
• Marital therapy (if appropriate)
• Family therapy (if appropriate)
• Occupational and vocational counseling
• Monitoring of medication, as needed
• Physical exam
• Development of discharge plan and plan for referral into continuum of care

The Required Staff in a Medically Managed Inpatient Residential facility are appointed according to the Joint Commission on the Accreditation of Hospital Organization’s (JCAHO’s) standard hospital practices. In addition, they must comply with the PA Department of Health’s staffing requirements.

The Staff who may be Recommended may include addiction counselors or registered, certified addiction clinicians able to administer planned interventions according to the assessed needs of the client.
### Dimensional Scoring Specifications

Clients must meet Level 4B criteria in all six dimensions. If the client exceeds Level 3B criteria in Dimension 1, the evaluator is directed to refer to Level 3A and 4A detoxification criteria.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Admission Criteria across 6 Dimensions</th>
</tr>
</thead>
</table>
| 1. Acute Intoxication or Withdrawal | Clients must meet all of the following:
A. The client is assessed as being at minimal to no risk of severe withdrawal syndrome, as evidenced by:
   1. CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol – Revised) score (or other comparable standardized scoring system) of less than 10 following 8 hours of abstinence from alcohol without medication; OR
   2. Blood alcohol 0.0gm% and no withdrawal signs or symptoms present which require medication; OR
   3. Sub-acute symptoms of protracted withdrawal which, if present, can be managed safely without daily monitored medical intervention.
B. For clients with withdrawal symptoms no more severe than those noted in Section A, the client has, and responds positively to, emotional support and comfort, as evidenced by decreased emotional symptoms by the end of the initial treatment session. |
<table>
<thead>
<tr>
<th>2. Biomedical Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td>A. Continued alcohol/drug use places the client in imminent danger of serious damage to physical health for concomitant biomedical conditions;</td>
</tr>
<tr>
<td>B. Biomedical complications of addiction require medical monitoring, or a concurrent biomedical illness needs medical management, but not intensive care;</td>
</tr>
<tr>
<td>C. Biomedical complications of addiction requiring intensive medical management and skilled nursing care;</td>
</tr>
<tr>
<td>D. Concurrent biomedical illness or pregnancy needing stabilization, medical management, and treatment with primary nursing interventions at least once every 8 hours;</td>
</tr>
<tr>
<td>E. Presence of biomedical problems requiring inpatient diagnosis, such as liver disease resulting in hepatic decompensation, acute pancreatitis requiring parenteral treatment, active gastrointestinal bleeding, cardiovascular disorders impairing daily activity and requiring medical adjustment, chronic obstructive pulmonary disease requiring continuous oxygen, recent cerebrovascular accident with neurological deficits, active infectious disease (e.g. HIV) requiring IV antibiotics and continuous monitoring, or multiple current biomedical problems requiring intensive medical management or treatment;</td>
</tr>
<tr>
<td>F. History of recurrent or multiple seizures;</td>
</tr>
<tr>
<td>G. Severe disulfiram (Antabuse)-alcohol reaction;</td>
</tr>
<tr>
<td>H. Life-threatening symptomatology related to excessive use of alcohol/drugs (e.g. stupor, convulsions, etc.) which requires intensive medical monitoring;</td>
</tr>
<tr>
<td>I. Previously diagnosed medical conditions, which require intensive medical monitoring, are being gravely complicated or exacerbated by chemical use;</td>
</tr>
<tr>
<td>J. Changes in client’s medical status, such as a severe worsening of medical condition which makes abstinence imperative, or daily improvement in a previously unstable medical condition which allows the client to respond to chemical dependency problem which requires excessive monitoring;</td>
</tr>
<tr>
<td>K. Client demonstrates other biomedical problems requiring 24-hr observation and evaluation.</td>
</tr>
</tbody>
</table>
3. Emotional/Behavioral Conditions and Complications

<table>
<thead>
<tr>
<th>Clients must meet at least 2 of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Emotional/behavioral complications of addiction require medical management and nursing care;</td>
</tr>
<tr>
<td>B. Concurrent emotional/behavioral illness needs stabilization, daily medical management, and primary nursing interventions;</td>
</tr>
<tr>
<td>C. Recent history of severe uncontrolled behavior endangering self or others;</td>
</tr>
<tr>
<td>D. Severe mental confusion or fluctuating orientation</td>
</tr>
<tr>
<td>E. Coexisting serious emotional/behavioral disorder which complicates the treatment of chemical dependency and requires differential diagnosis and intensive treatment;</td>
</tr>
<tr>
<td>F. Extreme depression or mania requiring intensive treatment;</td>
</tr>
<tr>
<td>G. Impairment in thought processes and abstract thinking, limitations in conceptual ability which impair client’s daily living activities;</td>
</tr>
<tr>
<td>H. Previously diagnosed psychiatric/emotional/behavioral condition gravely complicated or exacerbated by alcohol/drug use;</td>
</tr>
<tr>
<td>I. Altered mental status, with or without delirium, as evidenced by:</td>
</tr>
<tr>
<td>1. Disorientation to self, or</td>
</tr>
<tr>
<td>2. Alcoholic hallucinosis, or</td>
</tr>
<tr>
<td>3. Toxic psychosis.</td>
</tr>
</tbody>
</table>

4. Treatment Acceptance/Resistance

| N/A |

5. Relapse Potential

| N/A |

6. Recovery Environment

| N/A |
# Level 4B (Medically Managed Inpatient Residential)
## Continued Stay criteria across 6 Dimensions

| Dimensional Scoring Specifications |  
|------------------------------------|---|
| Clients must meet Level 4B criteria for all six dimensions. |  

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 1. Acute Intoxication or Withdrawal | Clients must meet ONE of the following:  
| | A. Acute symptoms of intoxication/withdrawal are absent in the client;  
| | B. Client exhibits symptoms of protracted withdrawal syndrome that are manageable without medical intervention and are not severe enough to interfere with participation in treatment;  
| | C. Client exhibits symptoms of post-acute withdrawal (e.g. increased irritability, mood swings, obsessive thoughts of substance use, high levels of anxiety) which present obstacles to engaging in recovery and normal life functioning;  
| | D. Client reports a limited lapse of sobriety that can be addressed constructively. |
| 2. Biomedical Conditions and Complications | Clients must meet ONE of the following:  
| | A. A continued biomedical problem or intervening medical event was serious enough to interrupt treatment, but the client is again progressing in treatment;  
| | B. A biomedical condition that was initially interfering with treatment is improving, yet the client still requires 24-hr continuous medical management for this condition, along with treatment for his/her addiction. |
| 3. Emotional/Behavioral Conditions and Complications | Clients must meet ONE of the following:  
| | A. Client is making progress toward resolution of a concomitant emotional/behavioral problem, but continued medically managed and nursing interventions are needed before a transfer can be made to a less intensive level of care;  
| | B. The client is being held pending transfer (within 48 hours) to an acute psychiatric inpatient service;  
| | C. The client is assessed as having a DSM Axis I psychiatric condition or disorder which, in combination with alcohol/drug use, continues to present a major mental health risk, and is actively being treated (e.g. medication stabilization). |
| 4. Treatment Acceptance/Resistance | N/A |
| 5. Relapse Potential | N/A |
| 6. Recovery Environment | N/A |
### Dimensional Scoring Specifications

Clients must meet Level 4B criteria in Dimensions 1, 2, 3, and 4.

<table>
<thead>
<tr>
<th>Dimensional Scoring Specifications</th>
<th>Discharge:</th>
<th>Referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Acute Intoxication or Withdrawal</strong></td>
<td>Clients must meet all of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The client is assessed as not being intoxicated or in withdrawal,</td>
<td></td>
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<tr>
<td></td>
<td>B. The client does not manifest symptoms of protracted withdrawal syndrome, and</td>
<td></td>
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<tr>
<td></td>
<td>C. The client does not meet any of the Level 4B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td></td>
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<tr>
<td></td>
<td><strong>Referral:</strong></td>
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<td></td>
<td>Clients must meet ONE of the following:</td>
<td></td>
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<tr>
<td></td>
<td>A. The client is abusing alcohol or other drugs, and is in need of a more intensive type of service;</td>
<td></td>
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<tr>
<td></td>
<td>B. The client does not meet any of the Level 4B Continued Stay criteria, but does meet the Admission criteria for a lesser type of service.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Biomedical Conditions and Complications</strong></td>
<td><strong>Discharge:</strong></td>
<td><strong>Referral:</strong></td>
</tr>
<tr>
<td></td>
<td>Client’s biomedical problems, if any, have diminished or stabilized to the extent that 24-hr medical and/or nursing management is no longer necessary, and he/she does not meet any of the Level 4B Continued Stay criteria for further treatment on any dimension at this level.</td>
<td>A biomedical condition has arisen, or an identified biomedical problem which is being addressed is not responding to treatment, and the client meets the Admission criteria for another type of service.</td>
</tr>
<tr>
<td><strong>3. Emotional/Behavioral Conditions and Complications</strong></td>
<td><strong>Discharge:</strong></td>
<td><strong>Referral:</strong></td>
</tr>
<tr>
<td></td>
<td>The client’s emotional and/or behavioral problems have diminished in acuity to the extent that daily medical and nursing management is no longer necessary, and the client does not meet any of the Level 4B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
<td>Clients must meet ONE of the following:</td>
</tr>
<tr>
<td></td>
<td>A. An emotional/behavioral condition has arisen, or an identified emotional/behavioral problem which is being addressed is not responding to treatment, and the client meets the Admission criteria for a more intensive type of service;</td>
<td>B. Client’s concomitant psychiatric and behavioral difficulties have stabilized, and the client meets the Admission criteria for a lesser type of service.</td>
</tr>
</tbody>
</table>
## 4. Treatment Acceptance/Resistance

<table>
<thead>
<tr>
<th>Treatment Acceptance/Resistance</th>
<th>Discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The client’s awareness of an addiction problem is sufficient to expect entry into continued addictions treatment in an appropriate type of service as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>1. The client’s recognition of the severity of his/her alcohol/drug problem, and by</td>
</tr>
<tr>
<td></td>
<td>2. The client does not meet any of the Level 4B Continued Stay criteria OR the Admission criteria for any other type of service.</td>
</tr>
<tr>
<td>Referral:</td>
<td>The client repeatedly refuses continued treatment despite motivating interventions, and the client does not meet any of the Level 4B Continued Stay criteria for further treatment on any dimension at this level. However, the client meets the Admission criteria for another type of service.</td>
</tr>
</tbody>
</table>

| 5. Relapse Potential            | N/A        |
| 6. Recovery Environment         | N/A        |
Appendix A:
Special Needs and Considerations

A vital component of the decision-making process in client placement concerns the determination of the client’s need for specialized services. There are several factors which should be taken into account when formulating an individual’s particular treatment plan. Specifically, issues which must be considered prior to a client’s placement include (but are not limited to) Pharmacotherapy, Co-Occurring Mental Illnesses, Gender, Parental Responsibilities, Sexual Orientation, and Culture and Ethnicity.

Before a determination of the client’s level and type of care, assessment questions which target special needs should be utilized. Affirmative responses to these questions require consideration of “Special Issue” criteria prior to client placement.

Information on specific tracks or programs can be obtained from your local Single County Authority (SCA) or the Bureau of Drug and Alcohol Programs.
Pharmacotherapy Considerations

Assessment Questions for Clients in Pharmacotherapy

- Is the client 18 or over, and has he or she been abusing opiates for one year or more?
- Does the client (age 18 or over) have HIV or AIDS?
- Is the client pregnant?
- Has the client previously been unsuccessful in non-pharmacologic treatments?
- Is the client experiencing acute withdrawal symptoms along with sustained medical complications?
- Is the client’s health at risk (e.g. because of IV drug use, or because of STD’s)?

Pharmacotherapy

Pharmacotherapy is a comprehensive treatment approach, requiring licensure, FDA, DEA, and PA Department of Health approval, where medication and comprehensive therapy and medical services are utilized for treatment of opiate addicted clients. Pharmacotherapies are safe and necessary pharmacological supports to control compulsive drug seeking behavior for chronic narcotic IV and other opiate-abusing clients. Medication can be either agonist (i.e. methadone, LAAM, etc.) or antagonist (Trexan, naltrexone, etc.), providing pharmacologic support to clients while they undergo structured specialized therapy and medical services.

Clients in Pharmacotherapy

Potential clients should be 18 years or older and have been addicted to opiates for over one year (as per federal regulations) to be eligible for this type of care. Pharmacotherapy is also the preferred course of treatment for narcotic addicted pregnant women, and it can be utilized with or without the one year documented history of addiction. Pharmacotherapy is also warranted if the client has a history of unsuccessful responses to non-pharmacologic detoxification or other treatment interventions. If the client has experienced or is experiencing acute opiate withdrawal symptoms, or his or her pattern of abuse is posing a significant health risk to self or others (i.e. a pattern of IV drug use), this method of treatment may again be the preferred route. Ideally, pharmacotherapy can help to curtail drug-seeking activity, and other related criminal behaviors, by relieving abstinence-withdrawal symptomatology and opiate cravings. It can also serve as an important step in the client’s commitment to a more intensive and responsible level of care, and put him or her in the position to regain control over his or her life circumstances and behavior.
Program Description

Pharmacotherapy programs are characterized by the following:

- Structured treatment involving some degree of periodic medical or clinical supervision (i.e. mandatory attendance of 2 or 3 to 7 days per week).
- An established daily dosage level (prescribed by a licensed physician) brought about by an adjustment to the medication in conjunction with therapy services.
- A comprehensive physical exam at the initiation of treatment, as well as subsequent annual exams and appropriate ongoing medical support.
- Provision of comprehensive primary health care for pregnant addicts.
- Required counseling interventions that are given as a condition for continued enrollment.
- Use of diagnostic medical testing, such as random urine toxicology tests.
- Provision of HIV/AIDS education for all clients, as well as testing and counseling for HIV/AIDS and TB.

The staff providing this type of care must be certified and have documented experience in narcotic addiction. They must also adhere to DOH staffing regulations, and comply with the limits and conditions of the client’s level of care.

Levels of Intensity

Pharmacotherapy in Outpatient settings (Level I) is conducted at two levels of intensity. At the Standard Level, it is assumed that the patient can sustain him or herself, although he or she would likely not benefit from treatment without the service. The facility provides the pharmacotherapy in addition to psychotherapy for 2+ hours a month. The Intense Level bundles a variety of services around clients at lower levels of functioning. These clients have numerous highly chronic and complex problems. Counseling for 2 to 10 hours per week is provided along with medical care and other services.

Clients in pharmacotherapy that exhibit difficulty with Outpatient treatment can engage in more intensive levels of care while being maintained in pharmacotherapy. In the Partial Hospital setting, therapy hours are increased to 10+ per week, while maintaining all the other services offered in lower levels. Length of stay is based on need, but otherwise the treatment is consistent with Level II. In a Residential Rehabilitation Treatment setting, sub-acute rehab is provided in conjunction with pharmacotherapy, as is consistent with Level III.
Co-Occurring Mental Illness Considerations

Assessment Questions for Mental Illness Considerations

- Does the client have a history of psychiatric problems and treatment?
- Is the client currently using prescribed psychotropic medicine?
- Does the client exhibit spiritual or other delusions when sober?
- Does the client exhibit unusual episodic or persistent behaviors?
- Does the client show signs of being at risk for causing harm to self or others?
- Does the client exhibit an inability to take care of basic hygiene?

Dual Diagnoses

It has become more widely recognized, over the past several years, that mental illness often coexists with substance use disorders, and that treatment must address both illnesses concurrently, and, if possible, in an integrated fashion, since each illness affects the course and severity of the other. Persons suffering from these two illnesses concurrently are said to have “dual disorders.” Attempts have been made to designate one disorder as the primary one and the other as secondary, in order to assign these clients to an easily identifiable setting within either the mental health treatment system or to addiction treatment, but these systems have historically never been well-integrated. Whether these persons are treated in an addiction treatment system, a mental health system, or an integrated system, the principles underlying their treatment must remain the same. Placement in an appropriately designed program will follow from adequate attention to the assessment of both disorders.

Dually Diagnosed Clients

Persons with dual disorders are by no means a heterogeneous group; there is great variability in the severity of each disorder and in the disability associated with each illness. This is often a source of great confusion in making determinations regarding the proper treatment setting for these individuals. The procedures for assessment must recognize the effects of substance use on one’s mental status and related psychiatric symptoms. In lieu of clear historical information, adequate time must be allowed to observe persons in a substance-free state before attempting to diagnose their present condition and long-term needs. Certain psychiatric symptoms must be recognized as likely impediments to establishing early abstinence and engaging in treatment, and addressed with sensitivity before they can be identified as primary co-occurring mental illnesses.

In many cases, persons who have severe substance use problems with mild psychiatric disorders that have little associated disability can be treated in programs designed primarily for the treatment of substance use disorders. By the same token, persons...
suffering from debilitating psychiatric disorders that are complicated by substance abuse may be treated in programs designed for persons with mental illnesses. For many clients, particularly those with severe disturbances resulting from both illnesses, specialized intensive programs are needed. Such persons may be identified by characteristics such as the following:

- Significant ongoing psychiatric symptoms which are present even when the client is abstinent, and which require management with psychotropic medications and rehabilitation programs.
- Significant dependence on substances with recurrent episodes of use, even when psychiatric symptoms are relatively under control.
- Little success in previous treatment and in managing recovery in less intensive or specialized treatment programs.
- Synergistic effects of combined illnesses cause significant disability and impaired functioning, such that treatment in less structured settings may result in behaviors that are potentially dangerous or harmful to self or others.

**Program Description**

Once the presence of a mental disorder has been established in a substance-abusing client, the following principles should guide the treatment:

- Treatment of both the mental illness and the substance use disorder should be integrated whenever possible; ideally, they should be provided in the same setting by the same treatment team.
- The treatment team must have professional resources available to ensure that adequate treatment of both disorders is possible. For example, the team should have psychiatric addiction specialists available, as well as other persons with both psychiatric and addiction training.
- All treatment team members should have some familiarity with the manifestations and etiology of both disorders to facilitate adequate coordination of treatment.
- Treatment planning should be individualized to address specific symptoms of all disorders, while recognizing that treatment will usually incorporate a variety of therapeutic methods which may address either or both of these illnesses.
- There must be provisions to incorporate the use of psychotropic medications when indicated.

Regardless of the treatment system, the personnel working with persons who have dual disorders will require training to enable them to understand and effectively address both mental health and substance use problems. This is sometimes referred to as "cross-training. This training should include education on the biological, environmental, and psychological aspects of both disorders, and current perspectives on integrated treatment of dually diagnosed clients.
Women’s Issues and Considerations

Assessment Questions for Women

- Does the client withdraw in a mixed-gender environment?
- Does the client have unresolved issues or problems resulting from past experiences of physical, emotional, and/or sexual abuse?
- Does the client lack communication skills, or resort to seductive behaviors, in a mixed-gender environment?
- Is the client pregnant?

Women’s Issues and Considerations

Substance-abusing women often require specialized care for issues and pathologies that arise as consequences of their addictions. Much more frequently than male addicts, females often face issues such as dysfunctional personal relationships, histories of emotional, physical, and/or sexual abuse, difficulties obtaining specific medical care, and the specific social stigma attached to being a female substance abuser. Following the determination of the level and type of care, the following considerations can help to determine if the client requires this form of treatment:

- The client shows signs of withdrawing in a mixed-gender environment, and has difficulty expressing her feelings and thoughts in the presence of males.
- The client needs further education in the areas of women’s health care and reproductive health.
- The client has a history of physical, emotional, and/or sexual abuse.
- The client lacks the appropriate communication skills to express anger and/or assert herself in mixed company, and has at times resorted to seductive behavior.
- The client needs to learn to establish and maintain healthy relationships with other females.
- The client needs child relationship training.

Program Description

A specialized program created to serve this population must have the following characteristics:

- Education meant to improve decision-making skills and self-esteem
- A focus on issues specific to women, such as addressing emotional, physical, and/or sexual abuse, single motherhood, difficulties with child care, and establishing oneself in a largely male-dominated society
• Extensive case management resources to accommodate the comprehensive needs of women in substance abuse care
• Educational programs that address parenting and child development skills, the prenatal and postpartum effects of substance abuse on children, and the reestablishment of the mother-child bond, if the child is not in the treatment setting or in the custody of the mother
• Additional education in the area of preventive health care (e.g. breast exams, pap smears, family planning, the risk of HIV/AIDS and other sexually transmitted diseases, etc.)
• Life skills training (e.g. communication skills, or budgeting and household management) that can maximize the client’s ability to provide a safe, clean environment for herself and her family.
• Education in legal issues (e.g. child custody, protection from abuse, divorce, and discrimination)
• A safe treatment setting that provides linkages to support groups
• Assistance in locating appropriate housing
• Education on eating disorders and referral for treatment, if necessary

Treatment Staff

The staff in facilities providing this type of care must be hired in a way that reflects the makeup of the client population. They must be certified, and have documented experience in women’s psychology and female-specific treatment. Finally, they must perform this treatment while complying with the conditions of the selected level of care.
Special Considerations for Women with Children

Assessment Questions and Considerations for Women with Children

- Does the client have any children under the age of 12?
- Is the client pregnant?
- Does the client have any children under another person’s custody (e.g. foster care, other relatives/extended family, child welfare)?
- Is there evidence of a seriously dysfunctional family (e.g. child neglect and/or abuse, domestic violence)?
- Client resides with an abusive partner, and is unwilling or unable to leave the relationship. The presence of an abusive partner requires special considerations by the assessor, such as recognizing how the woman’s entry into treatment could place her in greater danger of physical violence or otherwise affect her retention in treatment. Placement decisions should take into account the need to refer to providers who include in their programming special education and support to women who are experiencing these issues.
- The client resides with an abusive partner, and is unwilling or unable to leave the relationship, but may be eligible for a more restrictive level of care. The most available treatment for this client is likely to be at the Intensive Outpatient Level (1B).

Special Considerations for Women with Children

These programs are designed to serve substance-abusing pregnant and/or parenting women with specific pathologies and needs that have arisen in conjunction with their addiction. Treatment of women with children is more complex because of the problems presented by dysfunctional family dynamics, and because of this, the inclusion of children into the overall treatment process is warranted. Following the determination of the level and type of care, the following considerations can determine if the client requires this specific form of treatment:

- The client demonstrates little or no ability to communicate effectively on behalf of herself or her children.
- The client is pregnant or has children, and needs prenatal care, primary child health care, and the structure of a family-focused environment to support and manage her pregnancy.
- The client has or has regained custody of children, but is at high risk of losing custody in anything other than a structured, safe, drug-free environment.
- The client is in need of a supportive, educational environment, due to problem pregnancy, a history of abuse or neglect of children, physical health problems concerning herself or her children (e.g. HIV/AIDS), or developmental or emotional/behavioral problems in her children.
• The client’s lack of access to child care is presenting a barrier to treatment.
• The concurrent care of the client’s children is critical to her treatment outcome.

Program Description

In addition to meeting the characteristics of a specialized women’s program, parental responsibility programs assess and treat women from a holistic, family-centered point of view. The services of these programs are designed using gender-specific, culturally competent treatment models. Parental responsibility programs are characterized by the following:

• Parenting education and support services, as well as family therapy (for parents, significant others, non-resident children, etc.)
• Child development and prevention services including basic assessment of each resident child’s level of functioning
• Coordination of services addressing children’s developmental delays and/or mental health concerns
• Child care provided in an environment which promotes developmentally appropriate socialization, language and communication skills, and gross and fine motor skills. In such an environment, “high risk” families may have an opportunity for unification.
• Coordination of services establishing and maintaining public assistance benefits for herself and her children
• Child care services
• Early intervention and/or specialized education services designed to meet the developmental needs of the child.
• Life skills training (e.g. communication skills, and budgeting and household management) that maximizes the client’s ability to provide a safe, clean environment for the client and her children.
• Comprehensive treatment planning integrating parent/child activities and basic child development care.
• A focus on gender-specific issues such as addressing emotional, physical, and/or sexual abuse experiences in the client and her children.
• Educational programs that address parenting and child development skills (e.g. infant stimulation programs).
• A comprehensive service for children that includes a basic assessment, educational opportunities for developmental impairments, a physical and medical evaluation including a review of immunizations and a report of childhood diseases, and referral, if necessary.
• Alcohol and other drug education for children, including age-specific children’s groups to discuss these issues and improve coping skills.
• Education in child custody issues.

• Age-appropriate activities to encourage socialization and academic growth.
Treatment Staff

The staff in these programs must be certified, and have documented experience in child development, age-appropriate child care, and drug and alcohol prevention and education. They must also comply with the conditions of the selected level of care.
Cultural/Ethnic Considerations

Assessment Question for Cultural Considerations

- Is language a barrier to treatment?
- Does the client strongly identify with a specific cultural group?
- Is the client reluctant to seek treatment out of fear of being misunderstood or mistreated because of his/her cultural identity?
- Do the client’s beliefs impact on his/her perception of clinical dependency?
- Does the client exhibit difficulties interacting with the mainstream culture?

Cultural/Ethnic Considerations

People of racial or ethnic minorities often hold different views, values, norms, mores, and beliefs which affect the perception, impact, and severity of alcohol and other drug use. Particular care must be taken by treatment professionals concerning the issues of racism, language, communication styles, cultural and class values, and health-related values. There are several considerations that may help, once the level and type of care has been determined, to decide whether the client requires this specific mode of treatment. These considerations include:

- The client’s language presents a barrier to treatment.
- The client strongly identifies himself or herself with a specific cultural group.
- The client exhibits difficulty interacting with mainstream culture.
- The client is disconnected from the cultural group that would have the greatest beneficial effect on his/her recovery.
- The client is reluctant to seek treatment out of the fear of being misunderstood or mistreated due to his/her cultural/ethnic background.
- The client believes that substance use and addiction are the result of culturally specific spiritual beliefs.

Program Description

Programs offering this type of specialized treatment must be culturally competent, meaning that they are able to identify and address individual needs based on cultural differences, by way of policies, practices, attitudes, and agency structure. They are also characterized by the following:

- A program philosophy with cultural perspective that acknowledges that individuals and families make different choices based on differing cultural ideals.
- Treatment that is culturally relevant and includes the discussion of racism and other culturally-specific issues
- Culturally appropriate diagnostic tools and treatment methodologies
- Competency concerning the language and non-verbal communication styles typical of members of specific ethnic groups
- Décor, program material, and literature appropriate to the lifestyle and culture of the group being served
- Outreach services that mitigate cultural barriers to program access
- Coordination of services connecting clients to community resources and supports within the appropriate culture
- Integration of culturally-founded health beliefs and practices into the treatment plan
- Ongoing plans for training new staff and developing more competent programs

The treatment staff providing this kind of service must be able to communicate verbally and non-verbally with the population in question. Staffing patterns should reflect the make-up of the client population, and the staff should be knowledgeable in the history, culture, and behavior patterns of the client group being served. These personnel must also comply with the conditions of the selected level of care.
Sexual Orientation Considerations

Assessment Questions for Gay/Lesbian/Bi-Sexual Clients

- Does the client identify himself/herself as gay, lesbian, or bi-sexual?
- Is the client experiencing conflict over his/her sexual orientation?
- Is the client likely to decompensate in a traditional heterosexually oriented chemical dependency setting?
- Has the client previously experienced difficulties adjusting in a heterosexually oriented drug and alcohol treatment program?
- Has the client experienced relapse related to experiences of internal or external homophobia?

Gay/Lesbian Considerations

Individuals with a homosexual or bi-sexual orientation may present unique treatment needs because of many specific experiences that strongly affect emotions and behaviors. The experience of homophobia, a lack of social sanctioning, and religious and moral judgments which can lead to greater confusion and depression, and cause a higher incidence of chemical abuse or dependence, are all things which must be considered when developing drug and/or alcohol treatment plans for members of this group. Furthermore, accepting and affirming attitudes towards gays and lesbians on the part of the treatment staff are crucial to establishing a safe, positive treatment environment.

There are specific issues which may need to be explored concerning internal and external homophobia, as they may be critical to understanding and helping the client through chemical dependency treatment. These issues include:

- Sexual abuse, either during childhood or at present
- Conflicts over cultural and religious issues
- Bisexuality
- Domestic violence and codependency issues within gay and lesbian couples
- Degree of open acknowledgement of sexual orientation
- Parenting by gay or lesbian individuals
- Child custody issues and current child custody laws
- Homophobic attitudes and expressions by family members or coworkers
Program Description

Programs specially designed to treat this population are characterized by the following:

- A staff that includes other gays and lesbians who publicly identify themselves as such
- Sponsorship within the gay/lesbian recovery community, and the integration of gay/lesbian/bi-sexual identity issues into the recovery process
- Programs that address the specific needs of gay, lesbian, or bi-sexual clients that can interfere with chemical dependency treatment. Topic areas that should be discussed include: homophobia, both within the general community and in the client; the process of “coming out;” the social aspect of gay and lesbian culture; the roles of gay and lesbian parents; healthy relationships with biological and extended families; and the experience of spirituality, as it relates to systems that are traditionally judgmental and condemning
- HIV/AIDS policies including: a staff that is well-educated on the specific interrelationships between chemical dependency and HIV/AIDS, and sessions providing instructions on safer sex and HIV/AIDS risk reduction
- Specific education in areas of legal issues such as harassment, child custody, civil rights, and discrimination

The treatment staff in a facility providing this kind of care must be certified, and/or have documented training/experience in areas such as the psychology of homosexuality, emerging biological research and findings, the roles of gay, lesbian, and bi-sexual extended families, healthy gay, lesbian, or bi-sexual relationships, issues of civil rights, and HIV/AIDS education. The staff must also comply with the conditions of the selected level of care. Finally, ongoing skills training must be conducted, to help the program staff address the different cultural issues that arise in the gay/lesbian/bi-sexual community.
Appendix B:
Glossary of Terms

Admission: The point in an individual’s relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive the services of the treatment program.

Aftercare Plan: A plan for clients to follow after they leave formal treatment. This is the client’s individual plan for the future, and includes an identification of his or her personal goals and objectives.

Ancillary Services (or Wraparound Services): Services clients receive outside of the drug and alcohol treatment program itself. Most of these services are offered through other local agencies. Examples of ancillary services include health care, transportation, education, vocational training, stable and secure living environments, and support networks.

Appeal: A request for a reversal of a denial of authorization for a prescribed or recommended service that was made by an appropriately qualified practitioner.

Assessment: The process of gathering information to ascertain the degree and severity of alcohol and other drug (AOD) use, the social, physical, and psychological effects of that use, and the strengths and needs of the client.

Assessor: An individual who has knowledge, training, and experience in addictions.

Care Management (a.k.a. Service Management): The activities of screening, assessment (medical necessity determination), placement, authorization, continued stay/concurrent review, and utilization review.

Case Management: An organized system of coordinated activities developed and administered by the SCA to ensure client continuity of service, efficient and effective utilization of available resources, and appropriateness of service to meet the needs of each client.

Client: An individual who has applied for or has been the recipient of the services of a program. A client may be receiving drug services, alcohol services, or both.

Clinical Biopsychosocial Evaluation: The systematic collection and review of an individual’s specific data necessary to determine individual care needs, with a view towards developing an individual treatment plan.

Comorbidity: The occurrence of more than one disorder in the same client.
Concurrent Review: A routine review of the medical necessity for continued treatment, by an internal or external utilization reviewer, during the course of a client’s treatment.

Continued Stay Review: The process of reviewing the appropriateness of continued stay at a level of care and/or referral to a more appropriate level of care.

Counselor: An individual who meets the education and experience requirements listed in Chapter 704, and who provides a wide variety of treatment services which may include performing diagnostic assessments for chemical dependency, developing treatment plans, providing individual and group counseling and other treatments.

Cultural Perspective: Respect for the point of view of the constituency/constituencies served and for the dynamics of difference relative to their empowerment.

Culturally Competent: Sensitive to the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, gender, or social group, as demonstrated by a set of behaviors, attitudes, and policies that come together at all levels of a system, agency, or among professionals, and enable that system to work effectively in cross-cultural situations.

Culturally Relevant: The incorporation of the cultural knowledge of a particular group into practice and policy-making, through the sanctions or mandates of systems of care, agencies, or professionals.

Detoxification: The process whereby a drug or alcohol-intoxicated or dependent client is assisted through the period of time necessary to eliminate (by metabolic or other means) the presence of the intoxicating substance or dependency factors, while keeping the physiological or psychological risks to the client at a minimum. This process should also include efforts to motivate and support the client to seek formal treatment after the detoxification process.

Discharge: The point at which an individual’s active involvement with a treatment service is terminated, and he or she no longer is carried on the service’s records as a patient.

Drug: A substance:
1) Recognized in the official United States Pharmacopoeia or official National Formulary, or the supplements to either.
2) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals.
3) Other than food which is intended to affect the structure or function of the body of man or other animals.
4) Intended for use as a component of any article specified in subparagraph 1, 2, or 3, but not including devices or their components, parts, or accessories.

Drug-Free Approach: The provision of guidance, advice, and psychological treatment as a means to deal with the client’s emotional structure and concurrent problems, without
the use of a maintenance substance. Temporary medication, for treatment of physiological conditions or as an adjunct to psychosocial treatment may be utilized in this approach.

**Halfway House:** A community-based residential treatment and rehabilitation facility that provides services for chemically dependent persons in a supportive, chemical-free environment. While this type of service provides substance abuse treatment, it also emphasizes protective and supportive elements of family living, while encouraging and providing opportunities for independent growth and responsible community living, mutual self-help, assistance in economic and social adjustment, the integration of life skills into daily life, and a solid program of recovery. Clients entering this environment must have already had some experience in another type of drug and alcohol treatment. This is a live in/ work out environment.

**Inpatient Hospital Activity:** The provision of medically managed detoxification, treatment, and/or rehabilitation services, on a 24-hour basis, in a hospital. The hospital shall be licensed by the Department of Health as an acute care or general hospital, or be approved by the Department of Public Welfare as a psychiatric hospital.

**Inpatient Non-hospital Activity:** The provision of medically monitored residential treatment in a freestanding or health care-specific environment which provides one of the following drug and alcohol services:

- Residential treatment and rehabilitation services
- Short-term detoxification
- Halfway House care

**Instrument:** A measurement tool, usually a questionnaire, that is used for gathering information about an individual to aid screening, assessment, diagnosis, and/or clinical decisions.

**Intensive Outpatient:** An organized non-residential treatment service in which the client resides outside the facility. It provides structured psychotherapy and client stability through increased periods of staff intervention. Services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week, for a total time between 5 and 10 hours per week.

**LAAM:** Levo-alpha-acetylmethadol (a.k.a. the “Long Acting Methadone”). This is medication, used for opioid maintenance therapy, which is long acting and requires a client to receive dosage every third day.

**Length of Stay (LOS):** The number of days and/or sessions attended by clients in the course of primary treatment.

**Level of Care (LOC):** One of the four care settings, primarily differentiated by the intensity of service provided and the degree of client monitoring provided. Each level is

subdivided into Types of Services.
Maintenance (as in Pharmacotherapy): The prolonged scheduled administration of methadone or other pharmacological substances intended as a substitute or antagonist to abused opiate substances, in accordance with federal and state regulations.

Managed Behavioral Health Care: Any of a variety of strategies employed to control behavioral health (e.g. mental health and substance abuse) costs, while ensuring quality care and appropriate utilization. Cost-containment and quality assurance methods include the formation of preferred provider networks, gate keeping (or pre-certification), case management, relapse prevention, retrospective review, claims payment, etc.

Managed Care Organization: Those companies, organizations, states, counties, and EAPs that are charged with approving the treatment facility, the type(s) of treatment provided, and the amount spent on those treatments.

Medical Necessity: The determination that a specific health care service is medically appropriate, based on the biopsychosocial severity of the client’s situation and determined by a multidimensional assessment of the individual.

Medically Managed Inpatient Detoxification: An inpatient health care facility that provides a 24-hour medically directed evaluation and detoxification of psychoactive substance use disorder clients in an acute care setting.

Medically Managed Inpatient Residential: An inpatient health care facility that provides 24-hour medically directed evaluation, care, and treatment for addicted clients with coexisting biomedical and/or psychiatric/behavioral conditions which require frequent medical management. Such a service needs to have 24-hour nursing care, 24-hour access to intensive and specialized medical care, and 24-hour access to physician care.

Medically Monitored Inpatient Detoxification: A residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted clients.

Medically Monitored Long Term Residential: A residential facility that provides 24-hour professionally directed evaluation, care, and treatment for addicted clients in chronic distress, whose addiction symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. Habilitation is a treatment goal.

Medically Monitored Short Term Residential: A residential facility that provides 24-hour professionally directed evaluation, care, and treatment for addicted clients in acute distress, whose addiction symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a treatment goal.

Opioid: The term “opiate” refers to opium and derivatives of opium, a naturally occurring substance, whose effects are similar to those of morphine. Heroin, codeine, and morphine are examples of opiates. The term “opioid” refers to all substances, both those derived from opium and those synthetically produced, that have effects similar to...
morphine. Examples of opioids include heroin and codeine, which are natural derivatives of opium, and Demerol or Percodan, which are synthetics. Methadone can be used in opioid pharmacotherapy.

**Outpatient:** An organized, non-residential, drug-free treatment service providing psychotherapy in which the client resides outside the facility. Services are usually provided in regularly scheduled treatment sessions for, at most, 5 contact hours per week.

**Partial Hospitalization:** The provision of psychiatric, psychological, or other therapies on a planned and regularly scheduled basis in which the client resides outside the facility. Partial hospitalization is designed for those clients who would benefit from more intensive services than are offered in outpatient treatment projects, but who do not require 24-hour residential care. This environment provides multi-modal and multi-disciplinary psychotherapy. Services consist of regularly scheduled treatment sessions at least 3 days per week, for a total time of at least 10 hours per week.

**Peer Group Sessions:** Self-conducted group sessions monitored by a staff member of a halfway house, focusing primarily on daily living and coping skills.

**Pennsylvania Client Placement Criteria (PCPC):** Pennsylvania’s standards of clinical necessity, or guidelines for, alcohol and other drug (AOD) treatment that describe specific conditions under which patients should be admitted to a particular level of care (Admission criteria), conditions under which they should continue to remain in that level of care (Continued Stay criteria), and conditions under which they should be discharged from the system, or transferred to another level of care (Discharge/Referral criteria).

**Pharmacotherapy:** A comprehensive treatment approach where medication, comprehensive therapy, and medical services are utilized for treatment of opiate-addicted individuals. Medication, which can be either agonist (e.g. methadone, LAAM, etc.) or antagonist (Trexan, naltrexone, etc.), provides pharmacologic support to clients while they undergo structured, specialized therapy and medical services.

**Physician:** An individual licensed under the statutes of the Commonwealth of PA to engage in the practice of medicine and surgery in its branches, or to practice osteopathy or osteopathic surgery as defined in 1 PA C.S. 1991 (relating to definitions).

**Placement:** The process of matching the assessed service and treatment needs of a client with the appropriate type of service and level of care.

**Referral:** A formal process linking a client to an appropriate provider to address the client’s identified needs.

**Screening:** The first step in identifying the presence or absence of alcohol or other drug (AOD) use, whereby data is collected on an individual in order to make an initial determination if an alcohol or other drug problem exists and/or to determine if emergency services are warranted.
**Single County Authority (SCA):** The agency designated by the local authorities in a county or joinder to plan, fund, and administer drug and alcohol treatment activities. These are the agencies that BDAP uses as its primary contractor for this purpose.

**Sub-acute Protracted Withdrawal:** Withdrawal that is less severe than acute, but not yet chronic. It is a drawn-out withdrawal, with such signs as sleeplessness, anxiety, or confusion.

**Type of Service:** Services provided within the different levels of care. There are currently nine types of service.

**Xanax (Benzodiazepine):** Anti-anxiety agent in the Valium family.
With the implementation of the Pennsylvania Client Placement Criteria (PCPC) for Adults, client information is necessary for utilization of the criteria and the determination of medical necessity for service.

The PCPC Summary Sheet has been determined by the Bureau of Drug and Alcohol Programs (BDAP) and the Bureau of Community Program Licensure and Certification to fall within the parameters of state confidentiality regulation (4 PA Code 255.5 [b]).

The PCPC Summary Sheet provides for a brief summary of information pertaining to client status and progress in each of the six dimensional areas. This Summary Sheet may be used for disclosing necessary client information to determine client placement (medical necessity determination), and to facilitate the authorization of service and claims payment.

The PCPC Summary Sheet may be used by Single County Authorities (SCAs), Managed Care Organizations (MCOs), providers, and other parties who use the PCPC for admission, continued stay, discharge, referral, and concurrent review. It may also be used by parties responsible for the review of complaints and grievances as well as those who perform retrospective reviews.
Appendix C:
PCPC Summary Sheet

1. Client Name: _______________________________ SS#: __________________
   Reviewer/Therapist: __________________________ Phone # & Ext.__________
   Facility: ____________________________________ Date: __________________

Circle One: ADMISSION CONTINUED STAY DISCHARGE/REFERRAL

2. Show the level of care and criteria indicated for each dimension below (e.g.,
   Dimension 1: LOC 3A; Criteria 3A1.B):

   Indicate the level of care recommended, the program or facility referred to: _______
   ________________________________

   Indicate criteria in the following sections:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Criteria Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intoxication/Withdrawal</td>
<td>__________</td>
</tr>
<tr>
<td>2. Biomedical Conditions</td>
<td>__________</td>
</tr>
<tr>
<td>3. Emotional/Behavioral</td>
<td>__________</td>
</tr>
<tr>
<td>4. Treatment Accept/Resist</td>
<td>__________</td>
</tr>
<tr>
<td>5. Relapse Potential</td>
<td>__________</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>__________</td>
</tr>
</tbody>
</table>

3. A brief comment about the client’s progress or status is required in each dimension.
   For detox admissions, include in Dimension 1 amount, duration, and last use for
   each substance.

   Dimension 1: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   Dimension 2: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   Dimension 3: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   Dimension 4: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   Dimension 5: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

   Dimension 6: ________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
## Appendix D:
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar), Addiction Research Foundation (Second Edition)

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Date:</th>
<th>Time:</th>
<th>Pulse or heart rate, taken for 1 minute:</th>
<th>Blood pressure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAUSEA AND VOMITING: Ask, “Do you feel sick to your stomach? Have you vomited?”</td>
<td></td>
<td></td>
<td>TACTILE DISTURBANCES: Ask, “Have you any itching, pins-and-needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?” Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No nausea and no vomiting</td>
<td>0</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mild nausea with no vomiting</td>
<td>1</td>
<td>Very mild itching, pins and needles, burning, or numbness</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>2</td>
<td>Mild itching, pins and needles, burning, or numbness</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>3</td>
<td>Moderate itching, pins and needles, burning, or numbness</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Intermittent nausea with dry heaves</td>
<td>4</td>
<td>Moderately severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>Severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
<td>Extremely severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Constant nausea, frequent dry heaves and vomiting</td>
<td>7</td>
<td>Continuous hallucinations</td>
<td></td>
</tr>
<tr>
<td>TREMOR: Arms extended and fingers spread apart. Observation:</td>
<td></td>
<td></td>
<td>AUDITORY DISTURBANCES: Ask, “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No tremor</td>
<td>0</td>
<td>Not present</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Not visible but can be felt fingertip to fingertip</td>
<td>1</td>
<td>Very mild harshness or ability to frighten</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>2</td>
<td>Mild harshness or ability to frighten</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>3</td>
<td>Moderate harshness or ability to frighten</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Moderate, with patient’s are extended</td>
<td>4</td>
<td>Moderately severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>Severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
<td>Extremely severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Severe, even with arms not extended</td>
<td>7</td>
<td>Continuous hallucinations</td>
<td></td>
</tr>
<tr>
<td>PAROXYSMAL SWEATS: Observation:</td>
<td></td>
<td></td>
<td>VISUAL DISTURBANCES: Ask, “Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No sweat visible</td>
<td>0</td>
<td>Not present</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>1</td>
<td>Very mild sensitivity</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>2</td>
<td>Mild sensitivity</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>3</td>
<td>Moderate sensitivity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Beads of sweat obvious on forehead</td>
<td>4</td>
<td>Moderately severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>Severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>6</td>
<td>Extremely severe hallucinations</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Drenching sweat</td>
<td>7</td>
<td>Continuous hallucinations</td>
<td></td>
</tr>
</tbody>
</table>
### Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

#### Addiction Research Foundation

(continued)

<table>
<thead>
<tr>
<th>ANXIETY: Ask, “Do you feel nervous?”</th>
<th>HEADACHE, FULLNESS IN HEAD: Ask, “Does your head feel different? Does it feel like there is a band around your head?” Do not rate dizziness or lightheadedness. Otherwise, rate severity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0  No anxiety</td>
<td>0  Not present</td>
</tr>
<tr>
<td>1  Mildly anxious</td>
<td>1  Very mild</td>
</tr>
<tr>
<td>2</td>
<td>2  Mild</td>
</tr>
<tr>
<td>3</td>
<td>3  Moderate</td>
</tr>
<tr>
<td>4  Moderately anxious, or guarded, so anxiety is inferred</td>
<td>4  Moderately severe</td>
</tr>
<tr>
<td>5</td>
<td>5  Severe</td>
</tr>
<tr>
<td>6</td>
<td>6  Very severe</td>
</tr>
<tr>
<td>7  Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions</td>
<td>7  Extremely severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGITATION: Observation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
</tr>
<tr>
<td>0  Normal activity</td>
</tr>
<tr>
<td>1  Somewhat more than normal activity</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4  Moderately fidgety and restless</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7  Paces back and forth during most of the interview, or constantly thrashes about</td>
</tr>
</tbody>
</table>

**SCORE:_______** (maximum possible score=67)  
**Note:** This scale is not copyrighted and may be used freely.
Appendix E:
Narcotic Withdrawal Scale

There are four major stages of withdrawal: (Fultz & Senay, 1975)

GRADE 1: Lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, and insomnia

GRADE 2: Dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, and abdominal pain

GRADE 3: Tachycardia, hypertension, tachypnea, fever, anorexia, nausea, and extreme restlessness

GRADE 4: Diarrhea, vomiting, dehydration, hyperglycemia, hypotension, and curled-up position

HEALTHCHOICES BEHAVIORAL HEALTH RECIPIENT COVERAGE DOCUMENT

This document includes descriptions of policies supported by the Department's processes. In cases where the policy expressed in this document conflicts with another provision of the contract between the Primary Contractor and the Department (the Department Agreement), the Department contract will take precedence.

The Department will provide sufficient information to the Primary Contractor in order for it to reconcile Behavioral Health Managed Care Organization (BH-MCO) Membership data with amounts paid to and recovered from the Primary Contractor.

Definitions:

BH-MCO Coverage Period - A period of time during which a Recipient is eligible for Medical Assistance (MA) coverage and a BH-MCO coverage period exists on the Department’s Client Information System (CIS). Exceptions and Clarifications are identified in Sections D, E, F, G and H of this document.

BH-MCO Member - An MA Recipient who is enrolled with the BH-MCO under the HealthChoices Behavioral Health Program and for whom the BH-MCO is responsible to provide behavioral health services under the provisions of the HealthChoices Behavioral Health Program.

BH-MCO Member Record - A record contained on the Daily Membership File or the Monthly Membership File that contains information on MA eligibility, managed care coverage, and the category of assistance, which help establish the covered services for which a Recipient is eligible.

Child in Substitute Care – A Child in Substitute Care is one who has been adjudicated dependent or delinquent and residing outside their own home. Dependent children and adolescents are living in the legal custody of a public child welfare agency, in any of the following settings:

- Shelter programs
- Foster family homes
- Group homes
- Supervised independent living
- Residential treatment facilities (RTF)
- Drug and alcohol treatment facilities
- Transitional living residence
- Mobile and outdoor programs
- Residential facilities
- Kinship homes

Children in Substitute Care classified as delinquent are adjudicated as such by the juvenile court.
and placed in temporary secure juvenile detention center (JDC), secure care or any of the settings listed above. They are under the supervision of the juvenile court and there is no transfer of legal custody to a public agency.

**Client Information System (CIS)** - The Department's automated file of previous, current and future MA Recipients.

**Daily Membership File** - An electronic file generated by the Department using CIS on a daily basis (exclusive of weekends and Department holidays), which is transmitted to the Primary Contractor. The Daily Membership File contains information on changes made to MA Recipient records on CIS, and may include retroactive, current or prospective MA eligibility, and BH-MCO coverage information.

**Drug and Alcohol Residential Facility** – Includes inpatient or non-hospital residential drug and alcohol services. Non-hospital residential includes residential detox, rehab and half-way house.

**Eligibility Verification System (EVS)** - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, prepaid capitation, PH-MCO or BH-MCO enrollment, third party resources, and the benefit package under the MA Fee-For-Service (FFS) Program.

**MA Eligibility Period** - A period of time during which a Recipient is eligible to receive MA benefits. An eligibility period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date on CIS signifies an open-ended eligibility period.

**Monthly Membership File** - An electronic file generated by the Department using CIS on the next to the last Saturday of the month that is transmitted to the Primary Contractor. The Monthly Membership File lists retroactive, current and prospective BH-MCO Members, specifying for each BH-MCO Member the corresponding eligibility period, PH-MCO coverage and BH-MCO coverage. Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the BH-MCO unless a subsequent Daily Membership File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the BH-MCO if a Daily Membership File received by the BH-MCO prior to the beginning of the future month indicates otherwise.

**Negation BH-MCO Member Record** - A BH-MCO Member Record used by the Department to advise the Primary Contractor that a certain related BH-MCO Member Record previously submitted by the Department to the Primary Contractor should be negated. A Negation BH-MCO Member Record can be recognized by its illogical sequence of BH-MCO membership start and end dates with the end date preceding the start date.

**Open-ended** - A period of time that has a start date and does not have a definitive end date.

**PH-MCO Coverage Period** - A period of time during which a Recipient is eligible for MA
coverage and a PH-MCO coverage period exists on CIS. Exceptions and clarifications are identified in sections D, E, F and G of this document.

PH-MCO Member - An MA Recipient who is enrolled with a specific PH-MCO and to whom the PH-MCO is responsible to provide physical health MA benefits under the provisions of the HealthChoices Physical Health Program.

Physical Health Managed Care Organization (PH-MCO) - A Commonwealth licensed risk-bearing entity, which has contracted with the Department to manage the purchase and provision of physical health services under the HealthChoices Physical Health Program.

Provider Agreement MCO - An MCO that has a Provider Agreement with DPW to operate a voluntary MA managed care program.

Recipient - A person eligible to receive medical and behavioral health services under the MA program of the Commonwealth of Pennsylvania.

System Date – The System Date is the date a change in coverage or eligibility is entered into the system. The effective date of the change may be different than the System Date.

*******************************************************************************

A BH-MCO is responsible for a Recipient if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

A. Unless otherwise specified, the BH-MCO is responsible to provide MA behavioral health benefits to BH-MCO Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by DPW to each BH-MCO.

B. Monthly Membership Files containing information on Members are created on the next to the last Saturday of each month and are provided to the BH-MCO no later than the following Monday. Information on the file includes retroactive, current or prospective eligibility periods, PH-MCO coverage and BH-MCO coverage, and demographic data. For each BH-MCO member identified on the Monthly Membership File, the BH-MCO is responsible to provide behavioral health benefits from the beginning of the month or from the BH-MCO coverage start date, whichever is later. BH-MCO coverage will continue from the start date through the last day of the calendar month. BH-MCO coverage dates beyond the last date of the month in which a Monthly Membership File is created is preliminary information that is subject to change.

Daily Membership Files are provided to each BH-MCO with changes that have been applied to their enrolled population. In the example that follows, assume that the only
information provided by DPW is on the Monthly Membership File created in October. If an eligibility period of October 21 through November 18 is provided, the BH-MCO is responsible from October 21 through November 30, assuming no subsequent daily file changes occur prior to November 1 to end coverage in October. If two eligibility periods are provided, one from October 10 through October 25 and one from October 29 on with no end date, the BH-MCO is responsible from October 10 through at least November 30, subject to a daily file change prior to November 1. Coverage after October 31 is preliminary based on daily file changes.

If a Recipient is shown on the Department's Client Information System (CIS) as covered by a BH-MCO (coverage by a BH-MCO is indicated by an open eligibility record and a corresponding open HealthChoices BH-MCO record), the BH-MCO is responsible for that Recipient from the first day of coverage shown through at least the last day of that month or the BH-MCO end date, if any. The Department will pay the BH-MCO from the first day of coverage in a month through the last calendar day of the month. Information on CIS for any future month should be viewed as preliminary. If a Recipient has eligibility in more than one county during the month, the BH-MCO with the earliest period of responsibility is responsible for providing services for the month.

Recipients who become ineligible for Medical Assistance will retain their PH-MCO selection for six months. These Members will become the responsibility of the same PH-MCO and BH-MCO if they regain MA eligibility during that six-month period and their category of assistance and geographic location remain valid. Upon regaining eligibility, their BH-MCO effective date will be their MA eligibility begin date or the date CIS is updated, whichever is later. EXCEPTION: Members may voluntarily disenroll from a PH-MCO during the ineligibility period.

In some instances, Recipients temporarily “lose” MA eligibility (for example, due to failure to complete administrative paperwork, eligibility category change) but are reinstated back to the date eligibility was lost. In those cases where MA eligibility becomes continuous, the BH-MCO is responsible for payment of behavioral health services which they had been authorizing prior to the lapse and which continued during the lapse. The BH-MCO coverage is considered to be continuous rather than beginning on the System Date when the eligibility is reinstated. The BH-MCO begin-date should be modified through the Exception Site in order to receive the capitation that reflects the actual coverage dates.

C. DPW has established benefit packages based on category of assistance, program status code, age, and for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Recipient benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a Recipient has the most comprehensive package on the first of the month but changes to a lesser level package during the month, they should receive the higher level of benefits for the entire month. If a Recipient has a lesser level benefit package at the beginning of the
month but changes to a higher level during the month, they should receive the higher level benefits effective the first day of coverage under the higher level. The daily and monthly files can be used for determining increased benefits during a month.

D. Exceptions and Clarifications:

1. The BH-MCO will not be responsible and will not be paid when DPW sends the BH-MCO correspondence specifying member months for which they are not responsible. The Department will recover capitation payments made for Recipient for whom it had been determined the BH-MCO was not responsible to provide services.

2. If CIS shows Fee-For-Service (FFS) coverage that coincides with BH-MCO coverage, the Recipient may use either coverage and there will be no monetary adjustment between the Department and the BH-MCO. (This is subordinate to #8 below.)

3. If the BH-MCO has actual knowledge that a Recipient is deceased, and if such Recipient is shown on either the Monthly Membership File or the Daily Membership File as active, the BH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover capitation payments made for deceased Recipients for up to eighteen (18) months after the service month in which the date of death occurred.

4. If it is determined that the member was not MA eligible on the begin date of coverage during a month, and the BH-MCO was paid, the Department will recover or adjust payments.

5. If a member is placed in a setting that results in the termination of coverage by the BH-MCO, the Department will recover capitation payments made for the member for up to twelve (12) months after the service month in which the termination of coverage occurred.

6. The BH-MCO retains responsibility for Members when placed outside the county, HealthChoices zone or state by the BH-MCO, juvenile court or county Children and Youth (C&Y) even if PH-MCO coverage information is not found on CIS, or on the daily or monthly files. The BH-MCO will continue to receive capitation payments.

   If a member is placed in a facility by juvenile court or county Children and Youth authority for service(s) which the BH-MCO determines is not medically necessary, the cost of the service is the responsibility of the placing authority, not the BH-MCO. (See Section H for additional details).
7. Newborn babies are the responsibility of the BH-MCO that covered the mother on the date of birth. Where CIS does not reflect this, if the PH-MCO notifies the Department, the Department will coordinate adjustment of coverage. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

8. Movement out of a BH-MCO's service area, or lack of MA coverage or eligibility on a date of service for which the policies in this document otherwise hold a BH-MCO responsible for a Recipient do not negate a BH-MCO's responsibility to provide MA benefits. If a BH-MCO is aware that a Recipient is residing outside of its county, it is the BH-MCO’s responsibility to notify the County Assistance Office, within ten (10) days of the date of learning of the Recipient’s status.

9. If the rules to determine BH-MCO responsibility to provide benefits to MA Members that are outlined in this document indicate that a BH-MCO is responsible to provide benefits to a MA Recipient on a certain date, a lack of MA eligibility indicated on CIS for that date does not negate this responsibility.

10. Errors in coverage must be reported to the Department within 45 days of receipt of the monthly eligibility file in order for retroactive changes to be considered. The BH-MCO will be responsible to cover Members, even when coverage assignment resulted from errors, if not reported to the Department within 45 days unless the error results in duplicate payment or coverage.

11. If CIS shows an exemption or facility/placement code that precludes BH-MCO coverage, the Recipient may not be enrolled in a BH-MCO. If it is determined that the code in CIS was a legitimate error, the BH-MCO assumes responsibility for payment for services on the System Date of the change. The failure of an agency or CAO to enter a facility or placement code in a timely manner is not considered to be an error in coding.

E. When a Recipient has managed care coverage during part of an inpatient/residential stay, financial responsibility* is as follows: For purposes of this document, an inpatient/residential stay shall include those in the following facilities:

- General Hospital
- Rehabilitation Hospital
- Acute Care Psychiatric Hospital
- Extended Acute Care Psychiatric Hospital
- Residential Treatment Facility (Accredited- and Non-Accredited)
- Hospital-Based Drug & Alcohol Detoxification and Rehabilitation Facility

*The covering plan will only be responsible for inpatient/residential services for continuous stays when the service is included as a covered service under its contract with the Department.

1. Inpatient/residential Facilities Covered Under the Prospective Payment
Appendix V
Revised July 1, 2009

System for Diagnostic Related Groups.

If a Recipient is in a facility covered by a DRG and is FFS on the admission date (or determined eligible through a retroactive determination by the CAO) and the BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the FFS program is financially responsible for the entire initial stay. The BH-MCO will become financially responsible for the member upon discharge. Upon becoming aware of a new member currently in one of these facilities, the BH-MCO must coordinate with the Provider in determining an appropriate course of treatment as soon as possible, prior to discharge.

EXAMPLE: If a Recipient is determined to be covered by FFS on the admission date to an inpatient/residential facility, which is covered under the prospective payment system for Diagnostic Related Groups, on June 21, and the BH-MCO coverage begin date is July 1, and the individual is transferred/discharged on July 15, the FFS program will be financially responsible for the entire stay. The BH-MCO will be financially responsible for all covered services beginning July 15. Upon becoming aware of a new member currently in a facility on July 1, the BH-MCO must become involved in discharge planning for the individual.

2. Recipient Covered by FFS Becomes BH-MCO Covered While in Facility

If a Recipient is covered by FFS on the admission date and the BH-MCO coverage begins while the Recipient is in an inpatient/residential facility not covered under the DRG Prospective Payment System, the FFS program is financially responsible for the stay until the BH-MCO begin date. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for the remainder of the stay, as well as physician or other covered services not included in the inpatient/residential facility bill that would be their responsibility as the Recipient's BH-MCO. Upon assuming financial responsibility of a Recipient age 21 and over, the BH-MCO has the ability to conduct a concurrent review of the FFS authorized inpatient/residential facility stay to determine continued medical necessity.

EXAMPLE: If a Recipient covered by FFS is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on July 1. The FFS program will remain financially responsible for the stay through June 30. Anytime after June 30, the BH-MCO may conduct a concurrent review to determine medical necessity of the inpatient/residential facility stay if the member is an adult age 21 and over.

3. Recipient Covered by BH-MCO Becomes FFS While in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential
facility and the Recipient loses BH-MCO coverage and assumes FFS coverage while still in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

EXAMPLE #1: If the Recipient is still in the inpatient/residential facility on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of that month. The FFS program will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient covered by the BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 1, the FFS program will assume payment responsibility for the inpatient/residential facility stay on August 1. The BH-MCO will remain financially responsible for the stay through July 31.

EXAMPLE #2: If the Recipient is still in the inpatient/residential facility on the FFS program coverage begin date, and the Recipient's FFS program coverage begin date is any day other than the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The FFS program will be financially responsible for the stay beginning on the first day of the NEXT month. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 15, the FFS program will assume payment responsibility for the inpatient/residential facility stay on September 1. The BH-MCO program will remain financially responsible for the stay through August 31.

EXCEPTION #1: If the Recipient temporarily “loses” MA eligibility while in an inpatient/residential facility authorized by the BH-MCO, but the eligibility is re-instated back to the date it was lost, the BH-MCO is responsible for the “lapsed” period. In the majority of cases, coverage rules in Example #1 and #2 cover the lapsed period, but in some cases it may be longer. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on June 21, “loses” MA eligibility on August 1, and is reinstated retroactively on September 6 back to August 1, the BH-MCO is responsible for the period between August 1 and September 6 as well as for any period after September 6 for any services provided in that facility.

4. Recipient Covered by BH-MCO Becomes Covered by Different BH-MCO While in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and transfers to another BH-MCO while still in the inpatient/residential facility, the first BH-MCO is responsible for that stay except as indicated below.

EXCEPTION #1: If the Recipient is still in the inpatient/residential facility on the gaining BH-MCO coverage begin date, and the Recipient's gaining BH-MCO
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Revised July 1, 2009

coverage begin date is the first day of the month, the first BH-MCO will be financially responsible for the stay through the last day of that month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 1, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The first BH-MCO will remain financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the inpatient/residential facility on the second BH-MCO coverage begin date, and the Recipient's second BH-MCO coverage begin date is any day other than the first day of the month, the first BH-MCO will be financially responsible for the stay beginning on the first day of the NEXT month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the following month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 15, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 1. The first BH-MCO will remain financially responsible for the stay through August 31.

5. Recipients Covered by a Provider Agreement MCO

If a Recipient is covered by a Provider Agreement MCO that includes behavioral health services on the admission date and BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the Provider Agreement MCO is financially responsible for the stay except as indicated below. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for physician and other covered services not included in the inpatient/residential facility bill that would be their responsibility as the Recipient's BH-MCO.

EXCEPTION #1: If the Recipient is still in the inpatient/residential facility on the BH-MCO coverage begin date, and the Recipient's BH-MCO coverage begin date is the first day of the month, the Provider Agreement MCO will be financially responsible for the stay through the last day of that month. The BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Provider Agreement MCO covered Recipient is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The Provider Agreement MCO will remain financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the inpatient/residential facility on the BH-MCO coverage begin date, and the Recipient's BH-MCO coverage begin date is any day other than the first day of the month, the Provider Agreement MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The BH-MCO will be financially responsible for the stay
beginning on the first day of the NEXT month. For example, if a Recipient covered by the Provider Agreement MCO is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 15, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 1. The Provider Agreement MCO will remain financially responsible for the stay through August 31.

F. Other Causes for Coverage Termination:

1. Nursing Facility - BH-MCO Members are disenrolled after 30 consecutive days of placement in a nursing facility.

2. Pennsylvania Department of Aging (PDA) Waiver - BH-MCO Members are disenrolled 30 days after enrollment in the PDA Waiver.

3. Admission to a State Facility - BH-MCOs are not responsible for BH-MCO Members placed in a state facility. The Recipient will be disenrolled from the BH-MCO effective the day before placement in the facility and continued Medical Assistance eligibility will be determined by the County Assistance Office. The Department will recover capitation payments made for any months after the month of placement.

4. Admission to a Correctional Facility – A member who becomes an inmate of a penal facility or correctional institution (including work release), or a Member who is remanded to a Youth Development Center/Youth Forestry Camp will be disenrolled from the BH-MCO effective the day before placement in the facility. The Department will recover capitation payments made for any months after the month of placement.

5. Placement in a Juvenile Detention Center (JDC) – A member who is placed in a juvenile detention center is disenrolled from the BH-MCO after 35 days and covered through Medical Assistance Fee-For-Service. During the first 35 days of this JDC placement, the BH-MCO is responsible for all covered services that are provided to the member outside the JDC site; services provided inside the JDC are the responsibility of the FFS program.

6. Health Insurance Premium Payment Program (HIPP) - BH-MCO Members determined by the Department to be HIPP eligible (Employer Group Health Plan) will be disenrolled from the HC Program as of the date when the BH-MCO Member Record reflects such disenrollment. Additionally, HIPP eligible MA Members are prevented from enrolling in BH-MCOs.

7. A member enrolled in the LTCCAP (Long-Term Care Capitated Assistance Program, is disenrolled from the BH-MCO effective the day before the begin date of LTCCAP.
8. Residing in a PA Veterans Home* – BH-MCO will not be responsible for a Member residing in a PA Veterans Home. The Member will be disenrolled from the BH-MCO the day before admission date and enrolled in the MA FFS program.
*Effective January 1, 2009, contingent upon CMS approval of a State Plan Amendment. (Please Note: The Primary Contractor will be notified of the effective date when the change is approved by CMS)

G. Other Facility Placement Coverage:

1. Intermediate Care Facility-Mental Retardation or Other Related Conditions (ICF-MR or ICF-ORC) - Members placed in a private ICF-MR or ICF-ORC facility will continue to be covered by their BH-MCO for all medically necessary behavioral health services that are included in the scope of benefits provided by the contract with DPW.

2. Residential Facilities - BH-MCO Members placed by the BH-MCO in mental health and drug and alcohol residential treatment facilities will continue to be covered by their BH-MCO for all behavioral health services. The residential/treatment costs of Members placed by the BH-MCO in residential treatment facilities will be the responsibility of the BH-MCO. (See section H. 2 for exceptions for children in substitute care)

3. Extended Acute Care Psychiatric Hospital - BH-MCO Members admitted to an extended acute care psychiatric hospital will continue to be covered by their selected BH-MCO for all behavioral health services. The residential/treatment costs will be the responsibility of the BH-MCO.

H. Children and Adolescents In Substitute Care Issues:

When children have been adjudicated dependent or delinquent and are placed in substitute care, behavioral healthcare coverage is the responsibility of the BH-MCO. For purposes of this Section, terms “child” and “children” shall include “adolescents”. For a definition of Child in Substitute Care see “Definitions.”

1. Behavioral Health Services (includes MH and D&A)

If a child is placed in a substitute care setting, either in the same or different zone, the child is enrolled in the BH-MCO county of origin. The child remains enrolled in that BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-residential services. For a child placed in a substitute care setting out of zone, effective August 1, 2009 the child remains enrolled in the BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-
residential services.

2. **Placement in a Mental Health or Drug and Alcohol Residential Facility**

   a. **Medically Necessary** - Consistent with H.1 above, if a Child in Substitute Care is placed in a mental health or drug and alcohol residential treatment facility either in or out of state and the BH-MCO determines the placement is medically necessary, the behavioral health services are the responsibility of the BH-MCO.

   b. **Not Medically Necessary** - If a Child in Substitute Care is placed in a mental health or drug and alcohol residential facility by a placement authority or juvenile court and the BH-MCO in which the child is enrolled determines the placement is not medically necessary, the BH-MCO is not responsible for payment for the placement. The child remains enrolled in the BH-MCO and the BH-MCO remains responsible for medically necessary Behavioral Health Services other than the mental health or drug and alcohol residential placement.

   c. If a Child in Substitute Care enrolled in HC is placed in a mental health or drug and alcohol residential facility without review by the BH-MCO, the BH-MCO is not responsible for payment for residential behavioral health services. The BH-MCO will be responsible for medically necessary Behavioral Health Services other than the residential placement. The facility or placing authority can request authorization of services from the BH-MCO which will determine the medical necessity of the placement. The BH-MCO will not be responsible for any services delivered prior to the request for medical necessity determination unless, at the discretion of the placing authority and the BH-MCO, they can agree to begin BH-MCO coverage at the admission date or any mutually agreeable later date. The child is enrolled in PHSS serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health and for ancillary behavioral health services other than the placement. Ancillary services could include services such as assessments, psychotherapy, or medication management provided on an outpatient basis.

3. **Placement in a C&Y or JPO non-Mental Health Placement**

   If a Child in Substitute Care is placed in a non-mental health or drug and alcohol placement such as:
   
   a. Shelter programs  
   b. Diagnostic centers  
   c. Foster family home, including kinship care homes  
   d. Residential facilities  

   the child remains enrolled in the BH-MCO from the original placing county.

   The child is enrolled in PHSS serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health.
4. The BH-MCO will be required to pay for Out-of-Network medically necessary behavioral health care services for up to ten days for a child enrolled in its plan who is placed in substitute care if the CCYA cannot identify the child nor verify MA coverage. However, this Out-of-Network coverage will only be required in certain circumstances, such as emergency placement as determined by county child welfare or juvenile probation, or where the CCYA has had no contact with the child prior to the placement. All efforts must be made by the CCYA to identify the child and to determine MA coverage responsibility in the most expedient manner possible.

5. For youth placed in a juvenile detention center, the BH-MCO is responsible for medically necessary In-Plan Services delivered in treatment settings outside (off site) the juvenile detention center during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.

6. Children whose adoptions have been finalized by the court and for whom there is an adoption assistance agreement in place, enrolls in the BH-MCO of the county where the adoptive family resides. If the family has moved to a permanent residence outside the Commonwealth of Pennsylvania and the family retains Pennsylvania Medicaid for the adopted child, the child will revert to Fee for Service for behavioral health services.
<table>
<thead>
<tr>
<th>COUNTY OF CUSTODY =&gt; COUNTY OF PLACEMENT</th>
<th>PHYSICAL HEALTH (PH)</th>
<th>BEHAVIORAL HEALTH (BH)</th>
<th>BEHAVIORAL HEALTH (BH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside SE, SW or LC Zone =&gt; Inside Same Zone</td>
<td>Remains in same PH-MCO</td>
<td>Children Placed In Foster Care</td>
<td>Children Placed In MH RTF or C&amp;Y Licensed Group Home with MH Treatment Component and CRR Host Home</td>
</tr>
<tr>
<td>Placement Code 02, 55, 57</td>
<td>Placement Code 02</td>
<td>55 (placed by BH-MCO) Remains in BH-MCO Co. of origin. Placement Code 02 or 55</td>
<td></td>
</tr>
<tr>
<td>Inside SE, SW or LC Zone =&gt; Outside Same Zone</td>
<td>Becomes FFS; then must enroll in a HC PH-MCO where placed (if in HC zone) or in AccessPlus. Placement Code 03, 56, 58</td>
<td>Children Placed In Non-Hospital D&amp;A Rehabilitation Facility</td>
<td></td>
</tr>
<tr>
<td>Placement Code 03, 56, 58</td>
<td>Placement Code 03</td>
<td>56 (placed by BH-MCO) Remains in BH-MCO Co. of origin. Placement Code 03 or 56</td>
<td></td>
</tr>
<tr>
<td>Inside NE, NC =&gt; Inside Same Zone</td>
<td>Remains in AccessPlus or in current voluntary HMO if available. If HMO unavailable, must enroll in AccessPlus. Placement Code 04, 60, 62</td>
<td>Children Placed In non-Hospital D&amp;A Rehabilitation Facility</td>
<td></td>
</tr>
<tr>
<td>Placement Code 04, 60, 62</td>
<td>Placement Code 04</td>
<td>60 (placed by BH-MCO) Remains in BH-MCO Co. of origin. Placement Code 04 or 60</td>
<td></td>
</tr>
<tr>
<td>Inside NE, NC =&gt; Outside Same Zone</td>
<td>Becomes FFS; then must enroll in a HC PH-MCO or AccessPlus depending on where placed. Placement Code 05, 61, 63</td>
<td>Children Placed In non-Hospital D&amp;A Rehabilitation Facility</td>
<td></td>
</tr>
<tr>
<td>Placement Code 05, 61, 63</td>
<td>Placement Code 05</td>
<td>61 (placed by BH-MCO) Remains in BH-MCO Co. of origin. Placement Code 05 or 61</td>
<td></td>
</tr>
<tr>
<td>OUT-OF-STATE PLACEMENT CODE</td>
<td>PHYSICAL HEALTH</td>
<td>BEHAVIORAL HEALTH</td>
<td>BEHAVIORAL HEALTH</td>
</tr>
<tr>
<td>Inside HC Zone =&gt; Out-Of-State 2</td>
<td>99 (non medically necessary) PH-MCO coverage is end dated then becomes FFS. (N/A for C&amp;Y Lic. Grp. Home with MH Treatment Component/CRR Host Home)? Placement Code 99</td>
<td>99 (non medically necessary) BH-MCO coverage is end dated, then FFS for ancillary BH services. Placement Code 99</td>
<td>98 (placed by BH-MCO) Remains in BH-MCO Co. of origin. Placement Code 98</td>
</tr>
<tr>
<td>Children Placed In Non-Hospital D&amp;A Rehabilitation Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement Code 98 or 99</td>
<td>Placement Code 98</td>
<td>99 (placed by C&amp;Y/JPO) BH-MCO coverage is end-dated then becomes FFS for ancillary services. If FFS approved for mental health residential, reverts to HC and becomes placement Code 98</td>
<td></td>
</tr>
</tbody>
</table>

1. “Outside Same Zone” refers to a different HealthChoices zone than the child’s county of origin
2. Should be used on all out-of-state RTF and Non-Hospital D&A facility placements of CISC

NOTE: See Attached Facility Code Definitions
Appendix V, Attachment 1
Revised 1/23/09
## RTF and D&A Facility Placement For Children Not In Substitute Care
### HEALTHCHOICES (HC) DESK REFERENCE CHART
#### Payment and Coverage Responsibility

<table>
<thead>
<tr>
<th>COUNTY OF ORIGIN ⇒ COUNTY OF PLACEMENT</th>
<th>PHYSICAL HEALTH (PH)</th>
<th>BEHAVIORAL HEALTH (BH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside SE, SW ⇒ Inside or LC Zone ⇒ Inside Same Zone</td>
<td>Children in D&amp;A Facility (CIS Placement Code 01 or 98) RTF (CIS Placement Code 53 or 98) C&amp;Y Licensed Group Home w/MH Treatment Component, or CRR Host Home (CIS Placement Code 53)</td>
<td>Remains in HC PH-MCO in which the child is enrolled</td>
</tr>
<tr>
<td></td>
<td>Remains in HC PH-MCO in which the child is enrolled</td>
<td>Remains in HC BH-MCO in which the child is enrolled</td>
</tr>
<tr>
<td>Inside SE, SW ⇒ Outside or LC Zone ⇒ Same Zone</td>
<td>Initially in FFS, then child must enroll in HC PH-MCO in zone where placed (if in HC zone) or in AccessPlus.</td>
<td>Remains in HC PH-MCO in which the child is enrolled</td>
</tr>
<tr>
<td></td>
<td>Remains in AccessPlus or in current voluntary HMO if available. If HMO unavailable, must enroll in AccessPlus.</td>
<td>Remains in HC BH-MCO in which the child is enrolled</td>
</tr>
<tr>
<td>Inside NE, NC ⇒ Inside State/County Option ⇒ Inside Same Zone</td>
<td>Remains in AccessPlus or in current voluntary HMO if available. If HMO unavailable, must enroll in AccessPlus.</td>
<td>Remains in HC BH-MCO in which the child is enrolled</td>
</tr>
<tr>
<td>Inside NE, NC ⇒ Outside State/County Option ⇒ Same Zone</td>
<td>Becomes FFS; then must enroll in a HC PH-MCO (if in HC county) or AccessPlus depending on where placed.</td>
<td>Remains in HC BH-MCO in which the child is enrolled</td>
</tr>
</tbody>
</table>

### OUT-OF-STATE PLACEMENT CODE

<table>
<thead>
<tr>
<th>PHYSICAL HEALTH</th>
<th>BEHAVIORAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside HC Zone ⇒ Out-Of-State By BH-MCO</td>
<td>PH-MCO coverage is end-dated, then becomes FFS (N/A to C&amp;Y Lic. Grp. Home with MH Treatment Component/ CRR Host Home)</td>
</tr>
</tbody>
</table>

1 “Outside Same Zone” refers to a different HealthChoices zone than the child’s county of origin.
2 Should be used on all out-of-state RTF and Non-Hosp.D&A facility placements by the BH-MCO

**Note:** See Attached Facility Code Definitions

**Revised 01/27/09**
## Drug and Alcohol Residential Placement For Adults
### HEALTHCHOICES (HC) DESK REFERENCE CHART
#### Payment and Coverage Responsibility

<table>
<thead>
<tr>
<th>COUNTY OF ORIGIN</th>
<th>COUNTY OF PLACEMENT</th>
<th>PHYSICAL HEALTH (PH)</th>
<th>BEHAVIORAL HEALTH (BH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside SE, SW or LC Zone</td>
<td>Inside Same Zone</td>
<td>Remains in HC PH-MCO in which the adult is enrolled</td>
<td>Remains in HC BH-MCO in which the adult is enrolled</td>
</tr>
<tr>
<td>Inside SE, SW or LC Zone</td>
<td>Outside Same Zone¹</td>
<td>Initially in FFS, then must enroll in HC PH-MCO in zone where placed (if in HC zone) or in AccessPlus.</td>
<td>Remains in HC BH-MCO in which the adult is enrolled</td>
</tr>
<tr>
<td>Inside NE, NC State/County Option</td>
<td>Inside Same Zone</td>
<td>Remains in AccessPlus or in current voluntary HMO if available. If HMO unavailable, must enroll in AccessPlus.</td>
<td>Remains in HC BH-MCO in which the adult is enrolled</td>
</tr>
<tr>
<td>Inside NE, NC State/County Option</td>
<td>Outside Same Zone¹</td>
<td>Becomes FFS; then must enroll in a HC PH-MCO (if in HC county) or AccessPlus depending on where placed.</td>
<td>Remains in HC BH-MCO in which the adult is enrolled</td>
</tr>
<tr>
<td>OUT-OF-STATE PLACEMENT CODE</td>
<td>PHYSICAL HEALTH</td>
<td>BEHAVIORAL HEALTH</td>
<td></td>
</tr>
<tr>
<td>Inside HC Zone By BH-MCO</td>
<td>PH-MCO coverage is end-dated, then becomes FFS</td>
<td>Remains in HC BH-MCO in which adult is enrolled</td>
<td></td>
</tr>
</tbody>
</table>

¹ “Outside Same Zone” refers to a different HealthChoices zone than the adult’s county of origin.

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**NOTE:** SEE ATTACHED FACILITY CODE DEFINITIONS
Revised 01/27/09

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2 Should be used on all out-of-state D&A facility placements by the BH-MCO
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM
TFAC – FACILITY MATRIX TABLE DEFINITIONS

The codes identified below are separated into four sections. They are as follows:

Section I: Non-CISC Codes, In-State Placement

These codes relate to in-state services provided to children who are not in substitute care (CISC) with C&Y or JPO, as well as some adults.

Section II: Out-of-State Placement Codes, CISC and non-CISC

These codes relate to out-of-state mental health and drug and alcohol services for both CISC and non-CISC children.

Section III: CISC Codes for the Southeast, Southwest, and Lehigh/Capital Zones

These codes are for in-state placements of children in substitute care (CISC), both within the zone of their county of record, as well as in a different zone. The codes cover both mental health and drug and alcohol services, and include placements that are made by C&Y/JPO as well as those authorized by FFS or the HC plan.

Section IV: CISC Codes for the Expansion Zones

These codes are for in-state placements of children in substitute care (CISC), both within the zone of their county of record, as well as in a different zone. The zones for the Expansion include the Northeast, North/Central State Option, and the North/Central County option. The codes cover both mental health and drug and alcohol services, and include placements that are made by C&Y/JPO as well as those authorized by FFS or the HC plan.

Definitions:

C&Y/JPO Placement - A placement in a child welfare or JPO facility that is not an authorized MH placement and is not a D&A residential placement.

D&A Residential Placement – Drug and alcohol residential treatment facility that does not provide 24 hour physician monitoring

MH Residential Placement – Placements that include Mental Health RTF, CRR Host Home and C&Y Licensed Group Home

SE/SW/LC Zones – Consumer whose county of record is in the Southeast, Southwest, or Lehigh/Capital Zones
Appendix V
Attachment 4

Expansion Zones – Consumer whose county of record is in the Northeast, North/Central State Option, or North/Central County Option zones

CISC – Children in Substitute Care

Medically Necessary/BH-MCO authorized – “Medically necessary” assumes an authorization by either the BHMCO or FFS. “BH-MCO authorized” assumes an authorization by the BH-MCO.

SECTION I: NON-CISC CODES, IN-STATE

01 D&A Residential Placement in State, BH-MCO Authorized (Non-CISC)

BH-MCO authorized placement of a child not in substitute care into an in-state residential facility for the treatment of drug addiction or alcohol dependency. This code is not to be used for CISC or JPO placements.

01 D&A Residential Placement in State, Adult, BHMCO Authorized or Act 152

BH-MCO authorized placement of an adult into an in-state residential facility for the treatment of drug addiction or alcohol dependency. This placement code includes Act 152 placements.

53 MH Residential Placement in State, Medically Necessary (Non-CISC)

BH-MCO or MA FFS authorized placement of a child not in substitute care under age 21 into an in-state certified mental health residential treatment facility, CRR Host Home and C&Y Licensed Group Home with MH Treatment Component. (If a child is placed in an accredited RTF prior to his or her 21st birthday and is still in treatment on his or her 21st birthday, the child may remain in the facility up to his or her 22nd birthday). This code is not to be used for Children in Substitute Care.

SECTION II: OUT OF STATE PLACEMENT CODES – ALL ZONES

98 Out-Of-State BHMCO Authorized MH or D&A Placement (CISC and non-CISC)

Used for a BH-MCO authorized placement out-of-state for mental health or drug and alcohol services for children in substitute care as well as those not in substitute care.

### Out-Of-State Placements not BH-MCO Authorized

Used for an out of state placement not authorized by the BH-MCO. This code is appropriate for:

- **a.** C&Y/JPO placement of a child in substitute care into a children and youth or juvenile justice residential facility out of state. The child is FFS for physical health and ancillary behavioral health services.

- **b.** C&Y/JPO placement of a child in substitute care into a mental health or drug and alcohol facility without receiving authorization from the BH-MCO or FFS. The child is FFS for physical health and ancillary behavioral health services.

- **c.** FFS authorized out-of-state placement for mental health services. (Only for children not eligible for HC, i.e. HIPP, etc) If the child was eligible for HC prior to placement, the child reverts to HC coverage if the placement is approved by FFS as a mental health or drug and alcohol placement (becomes Code “98”)

- **d.** A PH-MCO authorized placement into an out-of-state facility.

### SECTION III: CISC Codes for Southeast, Southwest, and Lehigh/Capital Zones

#### 02 C&Y/JPO Placement Within Same Zone

C&Y/JPO placement of a child in substitute care who resides in a SE/SW/LC zone who is placed in a county within the same HC zone as the child’s county of record. The CAO is notified of a child being placed in substitute care via the CY 60 or 61. Not to be used for BH-MCO or MA Fee-for-Service authorized MH Residential Placement, or BH-MCO authorized Non-Hospital D&A Facility Placements. For those cases use Code 55 or 57 as appropriate.

#### 03 C&Y/JPO Placement In A Different Zone

C&Y/JPO placement of a child in substitute care (CISC) who resides in a SE/SW/LC zone who is placed in a county in a different HC zone than the child’s county of record. The CAO is notified of a child being placed in substitute care via the CY 60 or 61. This code is not to be used for BH-MCO or MA Fee-for-Service authorized RTF, CRR Host Home and C&Y Licensed Group Home with MH Treatment Component, or BH-MCO authorized Non-Hospital D&A Facility Placements. For these cases use Code 56 or 58 as appropriate.

**SOURCE:** TFAC – FACILITY MATRIX TABLE DEFINITIONS (CAO/MCO Version)

Commonwealth of Pennsylvania

HealthChoices Behavioral Health

PAGE 3

August 1, 2009
55  **Medically Necessary MH Residential Placement Within Same Zone**

BH-MCO or MA FFS authorized placement of a child in substitute care (CISC) into a certified mental health residential treatment facility (RTF), CRR Host Home and C&Y Licensed Group Home with MH Treatment Component, within the same HC zone of the child's county of record. *If the placement is not authorized by the BH-MCO or the Fee-For-Service program, FAC code 02 should be used.*

56  **Medically Necessary MH Residential Placement in a Different Zone**

BH-MCO or MA FFS authorized placement of a child in substitute care (CISC) into a certified mental health residential treatment facility (RTF), CRR Host Home and C&Y Licensed Group Home with MH Treatment Component. *If the placement is not authorized by the BH-MCO or Fee-for-Service program, FAC code 03 should be used.*

57  **Non-Hospital D&A BHMCO Authorized Placement Within Same Zone**

BH-MCO authorized placement of a child in substitute care (CISC) into a Non Hospital D&A Facility (residential treatment facility that does not provide 24 hour physician monitoring) within the same SE/SW/LC HC zone of the child’s county of record. *If the placement is not authorized by the BH-MCO, FAC code 02 should be used.*

58  **Non-Hospital D&A BHMCO Authorized Placement in a Different Zone**

BH-MCO authorized placement of a child in substitute care (CISC) into a Non Hospital D&A Facility (residential treatment facility that does not provide 24 hour physician monitoring). This code is to be used for a child from a SE/SW/LC HealthChoices zone, voluntary plan, ACCESS Plus or fee-for-service being placed in substitute care that does not meet the 57 criteria described above (includes zone-to-zone transfers). *If the placement is not authorized by the BH-MCO, FAC code 03 should be used.*

**SECTION IV: CISC CODES FOR EXPANSION ZONE**

04  **C&Y/JPO CISC Placement Within Same Zone**

C&Y/JPO placement of a child in substitute care who resides in an Expansion zone who is placed in a county within the same HC zone as the child’s county of record. The CAO is notified of a child being placed in substitute care via the CY 60 or 61. *Not to be used for BH-MCO or MA Fee-for-Service authorized MH Residential Placement, or BH-MCO authorized Non-Hospital D&A Facility Placements. For those cases use Code 60 or 62 as appropriate.*

**SOURCE:** TFAC – FACILITY MATRIX TABLE DEFINITIONS (CAO/MCO Version)
05  **C&Y/JPO CISC Placement in a Different Zone**

C&Y/JPO placement of a child in substitute care who resides in an Expansion zone who is placed in a county in a different HC zone than the child’s county of record. The CAO is notified of a child being placed in substitute care via the CY 60 or 61. *This code is not to be used for BH-MCO or MA Fee-for-Service authorized RTF, CRR Host Home and C&Y Licensed Group Home with MH Treatment Component, or BH-MCO authorized Non-Hospital D&A Facility Placements. For these cases use Code 61 or 63 as appropriate.*

60  **Medically Necessary Mental Health Residential Within Same Zone**

BH-MCO or MA FFS authorized placement of a child in substitute care (CISC) into a certified mental health residential treatment facility (RTF), CRR Host Home and C&Y Licensed Group Home with MH Treatment Component, within the same HC zone of the child's county of record. *If the placement is not authorized by the BH-MCO or the Fee-For-Service program, FAC code 04 should be used.*

61  **Medically Necessary Mental Health Residential in a Different Zone**

BH-MCO or MA FFS authorized placement of a child in substitute care (CISC) into a certified mental health residential treatment facility (RTF), CRR Host Home and C&Y Licensed Group Home with MH Treatment Component in a different zone than the child’s county of record. *If the placement is not approved by the BH-MCO or fee-for-service program, facility/placement code 05 should be used.*

62  **Non-Hospital D&A BHMCO Authorized Placement Within Same Zone**

Child in Substitute Care (CISC) placed into a Non-Hospital D&A facility (residential treatment facility that does not provide 24 hour physician monitoring) within the same BH Expansion HealthChoices zone as the child’s county of record. The placement is to be prior approved by the BH-MCO. *If the placement is not approved by the BH-MCO, facility/placement code 04 should be used.*

63  **Non-Hospital D&A BHMCO Authorized Placement in a Different Zone**

Child in Substitute Care (CISC) placed into a Non-Hospital D&A facility (residential treatment facility that does not provide 24 hour physician monitoring). This code is to be used for a child from the BH Expansion HealthChoices zone being placed in substitute care that does not meet the Code 62 criteria described above. The placement is to be prior approved by the BH-MCO. *If the placement is not approved by the BH-MCO, facility/placement Code 05 should be used.*

SOURCE: TFAC – FACILITY MATRIX TABLE DEFINITIONS (CAO/MCO Version)

Commonwealth of Pennsylvania
HealthChoices Behavioral Health

August 1, 2009
BEHAVIORAL HEALTH AUDIT CLAUSE

AUDITS

Annual Contract Audits

The Primary Contractor shall cause, and bear the costs of, an annual contract audit to be performed by an independent, licensed Certified Public Accountant. The contract audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be submitted to the Commonwealth no later than the 15th day of the fifth month after the contract period is ended.

If circumstances arise in which the Commonwealth or the Primary Contractor invoke the contractual termination clause or determine the contract will cease, the contract audit for the period ending with the termination date or the last date the contractor is responsible to provide medical assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth no later than the end of the fifth (5th) month after the contract termination date or the last date the contractor is responsible to provide medical assistance benefits.

The Primary Contractor shall ensure that audit working papers and audit reports are retained by the Primary Contractor's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the Primary Contractor's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the Primary Contractor's auditor.

Distribution shall be as follows:

Three (3) copies to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
1010 North 7th Street
Eastgate Building, Suite 316
Harrisburg, PA 17102-1410
Two (2) copies to:

Regular Mail: Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
P.O. Box 2675
Harrisburg, PA 17105-2675

Overnight Courier:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
DGS Annex Complex
Shamrock Hall, Bldg. #31, Room #116
112 East Azalea Drive
Harrisburg, PA 17110-3594

Annual Entity-Wide Financial Audits

The Primary Contractor and its Prime Subcontractor shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. If the Primary Contractor is a county government, the report on such audit shall be submitted within nine months after the end of the county’s fiscal year. If the Primary Contractor or Prime Subcontractor is not a county government, such audit shall be submitted to the Commonwealth within 180 days after the entity’s fiscal year end. If the Primary Contractor or Prime Subcontractor is a Commonwealth-licensed, risk-bearing entity, the annual audit prepared and submitted to the Pennsylvania Insurance Department, is acceptable for submission to the Department of Public Welfare.

Distribution shall be as follows:

One (1) copy to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
Assistant Comptroller for Medical Assistance
P.O. Box 2675
Harrisburg, PA 17105-2675
Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the Primary Contractor, its Prime Subcontractors or providers. Any such additional audit work will rely on work already performed by the Contractor’s auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the Primary Contractor, its Prime Subcontractors or providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

- Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this contract;

- Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions; and

- Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this contract.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the Primary Contractor’s or its Prime Subcontractor’s operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of Prime Subcontractors or providers will be performed at the Commonwealth’s discretion.

The following provisions apply to the Primary Contractor, its Prime Subcontractors and providers:

- Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the Primary Contractor, its Prime Subcontractors or providers (Entity) at least
three weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. While the audit team is on-site, the Entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The Primary Contractor shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The Entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.

- Upon issuance of the final report to the Entity, the Entity shall prepare and submit, within 30 calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

**Record Availability, Retention and Access**

The Primary Contractor shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor’s chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The Primary Contractor shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this agreement as well as to all required programmatic activity and data pursuant to this agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.
**Audits of Subcontractors**

The Primary Contractor shall include in Prime subcontract agreements clauses, which reflect the above provisions relative to “Annual Contract Audits”, “Annual Entity-Wide Financial Audits”, "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".

The Primary Contractor shall include in all contract agreements with other subcontractors or providers clauses, which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".
HealthChoices Behavioral Health Program
Program Standards and Requirements

Appendix X
HealthChoices Category/Program Status Coverage Chart

Attachment: PROMISE Managed Care Payment System Table for HealthChoices.

For Updates to the Category/Program Status Codes, access the following link:
http://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/recipcover/documents/mc_cat-hcbp.xls
<table>
<thead>
<tr>
<th>Category</th>
<th>Program Status Code</th>
<th>Description</th>
<th>HealthChoices Inclusion Yes/No</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>00</td>
<td>SSI Aged</td>
<td>Yes</td>
</tr>
<tr>
<td>A</td>
<td>44</td>
<td>SSI Aged State Supplement for SSI recipients (Known as the sandwich Group)</td>
<td>Yes</td>
</tr>
<tr>
<td>A</td>
<td>45</td>
<td>SSI Aged Nursing Home State Supplement for SSI recipients</td>
<td>Yes</td>
</tr>
<tr>
<td>A</td>
<td>46</td>
<td>SSI Aged Recipients who receive a Mandatory SSP will by SSA</td>
<td>Yes</td>
</tr>
<tr>
<td>A</td>
<td>60</td>
<td>SSI Aged Individual Receiving Dom Care Supplement</td>
<td>Yes</td>
</tr>
<tr>
<td>A</td>
<td>62</td>
<td>SSI Aged Individual Receiving PCBH Supplement</td>
<td>Yes</td>
</tr>
<tr>
<td>ACX</td>
<td>00</td>
<td>Act 150 (Ages 18-59) ((effective date delayed))</td>
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<tr>
<td>B</td>
<td>00</td>
<td>State Blind</td>
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<td>B</td>
<td>80</td>
<td>State Blind Pension</td>
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<tr>
<td>C</td>
<td>00</td>
<td>TANF</td>
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<td>04</td>
<td>TANF alien (Subject to 5 year bar)</td>
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<td>TANF Timeout</td>
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<td>Extended TANF - Contingency</td>
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<td>GA Chronically Needy</td>
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<td>GA RRP/RCA (Refugee Cash Assist)</td>
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<td>D</td>
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<td>Repatriated National</td>
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<td>GA Chronically Needy DAP (Pending Eligibility)</td>
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<td>SSI Disabled Federal Foster Care</td>
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<td>SSI Disabled Federal Adoption Assist</td>
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<td>SSI Adoption Foster Care Other State</td>
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<td>J</td>
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<td>J</td>
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<td>SSI Disabled Nursing Home State Supplement for SSI Recipients</td>
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<td>J</td>
<td>46</td>
<td>SSI Disabled Recipients who Received a Mandatory SSP will by SSA</td>
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<td>J</td>
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<td>SSI Disabled individual Receiving Dom Care Sup</td>
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<tr>
<td>J</td>
<td>62</td>
<td>SSI Disabled Individual Receiving PCBH Sup</td>
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<td>SSI Blind</td>
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<td>Category</td>
<td>Program Status Code</td>
<td>Description</td>
<td>HealthChoices Inclusion Yes/No</td>
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<td>SSI Blind Recipients who receive a Mandatory SSP will by SSA</td>
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<td>SSI Blind Indv Receiving Dom Care Sup</td>
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<td>M 62</td>
<td>SSI Blind Indv Receiving PCBH Sup</td>
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<td>Special SSI Group Widows/Widowers (reserved for MEDA)</td>
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<td>&quot;Pickle&quot; Aged (Reserved for MEDA)</td>
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*The presence of a facility or waiver code may influence HealthChoices enrollment or disenrollment.*

Last Revised 6/15/2005
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Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements – Primary Contractor - County
Appendix X
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Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements – Primary Contractor - County
Appendix X
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1) As of October 1, 2002, the Healthy Horizons recipient groups (62, 63, 64) will be replaced by the Healthy Horizons With Medicare (62M, 63M, 64M) and Healthy Horizons Without Medicare (62N, 63N, 64N) recipient groups.

Any capitation payments or adjustments with Dates of Service of October 1, 2002 and after, will be processed using the new recipient groups (62M, 63M, 64M, 62N, 63N, 64N).

Any capitation payments or adjustments with Dates of Service prior to October 1, 2002 will be processed using the old recipient groups (62, 63, 64).
“To access the current version of the HealthChoices BHSRCC, visit Intranet site (http://omhsas/burops/bhreport.htm) Scroll down to encounter data and click on HealthChoices BHSRCC”.
HealthChoices Supplemental Services and Out-of Network Provider Enrollment for Providers, Counties and Behavioral Health Managed Care Organizations

1. The HealthChoices enrollment process for supplemental service providers begins when a county or Behavioral Health Managed Care Organization (BH-MCO) identifies a service need and credentials and contracts with a provider. The following steps are included in this process:

A. The county/BH-MCO identifies the need for a supplemental service(s) and an appropriate provider (or providers) to deliver the supplemental service(s).

B. The county/BH-MCO works directly with the Provider(s) to make application for supplemental services or for an out-of-network Provider.

C. The Provider(s), with assistance from the county/BH-MCO, completes an enrollment application. The enrollment application includes:
   - HealthChoices Supplemental Services Provider Enrollment Application;
   - Provider Agreement for Outpatient Providers;
   - Ownership or Control Interest Form;
   - Document Generated by the Federal IRS listing name and FEIN or SSN;
   - Supplemental Service Description (where applicable);
   - BH-MCO Attestation Form;
   - OMHSAS Field Office Attestation Form (where applicable);

D. There are two categories of Supplemental Services which require a supplemental service description (SSD) tailored to describe the provider-specific information. They are “standard” and “newly proposed.”

The “standard” HealthChoices Supplemental Services which require the submission of a Supplemental Service Description (SSD) with the provider enrollment application include:

- BSU Diagnostic Assessment
- Drug and Alcohol Intervention
- Drug and Alcohol Intensive Case Management
- Drug and Alcohol Resource Coordination
- Drug and Alcohol Level of Care Assessment

A “newly proposed” HealthChoices Supplemental Service should fall into one of the 3 categories listed below:
OMHSAS reviewers will ensure the SSD is consistent with the service requirements, and completed to describe the service as it is proposed to be delivered by the provider. Service descriptions that are incomplete or do not reflect provider-specific information will be returned to the County/BH-MCO.

A Service Description must be completed for each requested supplemental service. The Enrollment Form identifies standard (i.e., existing Supplemental Services). Whether the county/BH-MCO is requesting one of these standard services or a brand new service not included on the form, a Service Description Form must be completed. The county/BH-MCO needs to review the Office of Mental Health and Substance Abuse Services’ (OMHSAS) list of Supplemental Services service descriptions, which have standard descriptions, staff qualifications, expected outcomes, and other information to determine if the particular service being considered is included.

If the supplemental service is not on the standard supplemental services list, the county/BH-MCO assists the provider to develop a new supplemental service description.

- **Date of Submission** - list the date the County Contractor/BH-MCO submitted the service description for review and approval;
- **Provider’s Name** - Enter the name of the provider who will be providing this service;
- **Service Name** – Enter the name of the proposed service;
- **County/BH-MCO Name** – enter the name of the County Contractor/BH-MCO who is requesting this new service;
- **Description of Service** - complete this section;
- **Coding for Billing and/or Reporting of Services Rendered** – complete this section;
- **Anticipated Units of Services per Person** - complete this section;
- **Targeted Length of Service** - complete this section;
- **Information About Populations to be Served** - complete the table indicating the population, age ranges, projected numbers, and characteristics;
- **Program Philosophy, Goals, and Objectives** - complete this section;
- **Expected Outcomes** - complete this section;
- **Clinical Staffing Patterns** – complete this section;
- **Cost-Benefit Analysis** - complete this section.
E. The county/BH-MCO reviews the enrollment application for accuracy and completeness and completes the actions to credential the provider.

F. If the original or modified enrollment application is accepted and is complete, the Appropriate entity signs the Attestation Form and forwards the enrollment application to the OMHSAS Field Office – when applicable.

G. OMHSAS Field Office (when applicable) - will review the enrollment application for completeness and for determination of the desire to include the supplemental services provider and submit the new service description for review and approval through the Service System Review Committee (SSRC). After approval is received, the Field Office representative signs the Field Office Attestation Form and secures it to the front of the enrollment application.

H. OMHSAS has delegated the approval of OON providers to the County/BH-MCO. It is the BH-MCO’s responsibility to enter into a written agreement with an OON provider, and to report person level encounters for the usage of OON providers. Out-of-network providers are not entered into the PROMIS™ system. Consideration should be given to bringing frequently-used OON providers into the BH-MCO’s network to ensure inclusion in the BH-MCO’s quality management review.
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
DEPARTMENT OF PUBLIC WELFARE
PRIOR AUTHORIZATION REQUIREMENTS
FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE
ORGANIZATIONS
IN THE HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT
The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department’s approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. For each service to be prior authorized, the BH-MCO must submit for the Department’s review and approval the written policies and procedures in accordance with the guidelines described below.

The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices (HC) contract, including applicable policy in Medical Assistance General Regulations, Chapter 1101, the Request For Proposal (RFP) and DPW regulations;
- ensure that physical or behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved prior authorization proposal. Any deviation from the Department’s approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in sanctions/or penalties by the Department.

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The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

The OMHSAS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the BH-MCOs.

**B. GUIDELINES FOR REVIEW**

**1. Basic Requirements:**
   a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

**2. Medical Necessity Requirements:**
   a. The BH-MCO must describe the process to validate medical necessity for:
      - covered care and services
      - procedures and level of care
      - medical or therapeutic items

   b. The BH-MCO must identify the source of the criteria used to review the request for prior authorization of services. The criteria must be consistent with the HC RFP definition of medical necessity.

   c. Medical necessity criteria used by BH-MCOs must conform to Appendix T of the HC BH RFP.

For BH-MCOs, if the criteria being used are:

- purchased and licensed, the BH-MCO must identify the vendor;
- developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
- based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
- based on the medical training, qualifications, and experience of the BH-MCO’s Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

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d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the member’s condition or disease in accordance with CMS Guidelines, the HC RFPs, and applicable legal settlements.

For children under the age of 21, requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the member’s condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or
- that the service or item is not medically necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements

a. The BH-MCO’s written policies and procedure must demonstrate how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

b. The BH-MCO’s written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO’s overall Quality Management Plan.

4. Notification, Grievance, and Appeal Requirements
The MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the member notification requirements and member grievance and appeal requirements of the HC RFPs.

5. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)
For purposes of tracking/care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify providers of this notification requirement. This process may not be administratively cumbersome to providers and members. These situations need not comply with the other prior authorization requirements contained in this Appendix.
C. Prior Authorization Review and Decision Process:

1. Timeframes for Notice of Decisions

   a. The Contractor is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the member is notified of the decision as expeditiously as the member’s health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made.

   b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the provider within 48 hours of receipt of the request and allow up to 14 days for the provider to submit the additional information.

   c. The BH-MCO must provide written notice to the member that additional information has been requested; on the date the additional information was requested, using the template supplied by the Department as Attachment 1.

   d. If the requested information is provided within 14 days, the BH-MCO must make the determination to approve or deny the service and notify the member orally, within 2 business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made. If the additional information is not received within 14 days, the decision to approve or deny the service must be made based upon the available information and the member notified orally within 2 business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made.

   e. In all cases, if the member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) days from the date the BH-MCO received the request, the service is automatically approved. To satisfy the twenty-one (21) day time period, the Contractor may mail written notice to the Member, the Member’s PCP, and the prescribing Provider on or before the eighteenth (18th) day from
the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, then the BH-MCO must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

f. If the member is currently receiving a requested service, the written notice of denial must be mailed to the member at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable recipient fraud has been verified, the period of advance notice is shortened to five (5) days. For inpatient services, the effective date on a denial of a continuation of services must be at least one day after the date of the notice. If the member wishes to have services continued as previously approved, the member must file a grievance or request a DPW Fair Hearing before the effective date of the denial as indicated on the denial notice.

g. Advance notice is not required when the agency has factual information confirming the death of a recipient; the agency receives a clear written statement signed by a recipient that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the recipient has been admitted to an institution where s/he is ineligible under the Contract for further services; the recipient’s whereabouts are unknown and the post office returns agency mail directed to the recipient indicating no forwarding address; the recipient has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the recipient’s physician.

2. Denial of Service:
A determination made by a BH-MCO in response to a provider’s or member’s request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely, or
b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested or
c. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
d. reduces, suspends, or terminates a previously authorized service.

NOTE: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

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2. The service requested is not a covered service.
3. Authorization Decisions:
A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the psychologist’s scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:
A written denial notice must be issued to the member using the notice template provided by the Department as Attachment 2 of this Appendix when a service is denied as defined in Section C.2. of this Appendix.
APPENDIX AA
ATTACHMENT 1
Notice of Request for Additional Information

[Date additional information was requested from Provider]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Request for Additional Information from your Provider

Dear [Member Name]:

[MCO Name] received a request for [describe specific services] from [provider name] on [date received].

In order to decide if this service is medically necessary for you, [MCO Name] has requested the following additional information from your provider by [date]:

[list specific information requested]

[MCO Name] will make a decision on the requested services within 2 business days after receiving the additional information from your provider. [MCO Name] will notify you in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. [MCO Name] will notify you in writing within 2 business days after we should have received the additional information.

If you have any questions, please contact Member Services at [phone #].

Sincerely,

[MCO Name]

cc: Prescribing Provider

[MCO: The following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:] The information in this notice is available in other languages and formats by calling [Plan’s Member Service’s phone #].

Final 3/29/04
APPENDIX AA
ATTACHMENT 2a

STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member's name and DOB]

Dear [Member Name]:

[MCO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber’s name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Denied completely because: [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address

2) File a Complaint or Grievance

Final 3/29/04
You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

- Call [MCO Name] at [phone #]; or
- Send your complaint or grievance to [MCO Name] at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [MCO Name] at [phone #]
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter, or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Final 3/29/04

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Appendix AA

Division of Grievances and Appeals
Beechmont Building # 32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a fair hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

Address for records information

Final 3/29/04

4) Get a second opinion

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.
If you have any questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract.]

The information in this notice is available in other languages and formats by calling [MCO Name] at [phone #].

Final 3/29/04
APPENDIX AA
ATTACHMENT 2b

STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member’s name and DOB]

Dear [Member Name]:

[MCO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber’s name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Approved other than as requested as follows: [Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied].

The service is not approved as requested because: [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision]

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements – Primary Contractor - County

Final 3/29/04
2) File a Complaint or Grievance

You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

- Call [MCO Name] at [phone #]; or
- Send your complaint or grievance to [MCO Name] at the following address:

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [MCO Name] at [phone #]
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter, or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.
Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a fair hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

Address for records information

4) Get a second opinion
Appendix AA

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service or item that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information contained in this notice is available in other languages and formats by calling [MCO Name] at [phone #].

Final 3/29/04
APPENDIX AA
ATTACHMENT 2c

STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member’s name and DOB]

Dear [Member Name]:

[MCO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber’s name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Denied as requested, but the following service is approved: [describe the specific service approved, including the level, frequency, and duration of service].

A different service is approved because: [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

Final 3/29/04

MCO address
2) File a Complaint or Grievance

You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

- Call [MCO Name] at [phone #]; or
- Send your complaint or grievance to [MCO Name] at the following address:

  MCO address for filing complaint or grievance

  To ask for an early decision

  If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

  - Call [MCO Name] at [phone #];
  - Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter, or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

  Final 3/29/04

Your request for a fair hearing must be sent to the following address:

  Department of Public Welfare  
  Office of Mental Health and Substance Abuse Services
The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

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Address for records information

Final 3/29/04

4) Get a second opinion

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.
If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract.]

The information contained in this notice is available in other languages and formats by calling [MCO Name] at [phone #].
REGULATIONS AND POLICIES NOT APPLICABLE TO HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Regulations and policies not applicable to HealthChoices Behavioral Health:

DEPARTMENT OF PUBLIC WELFARE, OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES REGULATIONS:

Chapter 4300 County Mental Health and Mental Retardation Fiscal Manual
   4300.11
   4300.22, 4300.23
   4300.25 through 4300.28
   4300.41 through 4300.69
   4300.81 through 4300.108
   4300.111 through 4300.118
   4300.131 through 4300.160

Chapter 5221 Mental Health Intensive Case Management
   5221.42 (b)(c)(e)(f)(g)
   5221.42 (h) ...100% of the approved expenditures for...

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETINS:

OMH-91-19 Transmittal of General Family-Based Mental Health Services Program Issues
   P.2, #7
   P.8, #40
   P.9, #46,47
   P.11,#56,57
   P.12,#62
   P.13,#67,70
   P.14,#72-75
   P.16 #1

OMH-92-16 Mental Health Crisis Intervention Services: Implementation
   Attachment (A),(B)
   Attachment (C) - Payment
   Subsections (A-E) - Payment Conditions
OMH-93-10 Mental Health Crisis Intervention Services Guidelines
Issues (1),(2),(3),(4),(8),(9)

00-88-14 Fee Schedule Revisions and Transportation Requirements.

4000-95-01 Room and Board Payments for Mental Health Only Children in Residential Facilities Which Are Not JCAHO Accredited.

OMH-94-07 180 Day Exception Requests and Invoice Submission Time Frames.

OMH-95-01 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians

OMH-93-09 Resource Coordination: Implementation.
Attachment (A),(B)
Attachment C,- Service Description "The implementation of Resource Coordination services is optional at this time."
Payment

00-88-03 Appropriate Billing for Psychiatric Partial Hospitalization Services and Psychiatric Outpatient Clinic Providers.

OMH-96-04 Procedures for Claiming Federal Reimbursement on Administrative Costs for Medicaid Funded MH Services

OMH-94-09 180 Day Exception Requests of MA Invoices.

OMHSAS-99-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians.

OMHSAS-05-01 Cost Settlement Policy and Procedures for Community-Based Medicaid Initiatives.

OMH-96-05 Mental Health Crisis Intervention (MHCI) Fee Schedule.

Administrative Bulletin 7021-03-03 Maximum Rates of State Participation for the County Mental Health/Mental Retardation Programs.
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CONTRACT ADDENDUM:

Chapter 5260 Family Based Mental Health Services for Children and Adolescents
5260.12 (b)(c)(d)
5260.22 (b) (1-7)
5260.45 (e)(f)(g)(i)(j)(k)
5260.46
Note: The above exceptions also apply to the Family-Based Mental Health Services Contract Addendum.

OFFICE OF MEDICAL ASSISTANCE REGULATIONS:

§1151 Inpatient Psychiatric Services
1151.2 Definition of benefit period
1151.21(b) "...for up to 60 days."
1151.34
1151.41(b)(c)(1-2)(d)(i)&(j)
1151.42(a)(c)(d)
1151.43(a)(b)
1151.45(2)(3)
1151.46
1151.48(a)(2-6)(9-16)(18-20)
1151.52
1151.53
1151.54

§1153 Outpatient Psychiatric Services
1153.2 Definitions - Psychiatric Partial Hospitalization:"... a maximum of six hours in a 24 hour period"
1153.14 (2)(3)(9)
1153.52(a)(2) "separate billings for these additional services are not compensable"
1153.53 Limitations on Payment
1153.53a Requests for Waiver of Hour Limits
§1163 Inpatient Drug and Alcohol Services
  1163.59
  1163.455

§1223 Outpatient Drug and Alcohol Clinic Services
  1223.12 Outpatient services "...fee for service."
  1223.14 (3)(4)(8)(9)(14)
  1223.52(2)(3)(b,4,c)
  Separate billings for these interviews are not compensable."
  1223.53 Limitations on Payment.

OFFICE OF MEDICAL ASSISTANCE BULLETINS:

01-93-04, 11-93-02, 13-93-02, 41-93-0201-93-04, 11-93-02, 13-93-02, 41-93-02 (a.k.a., 1165-93-01, 53-93-02)
Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age (applies to JCAHO accredited RTF’s only)
  Page 1, 1st paragraph
  Page 3, Number 4
  Section C. Payment for Service
  Section D. Request for prior authorization
  Section E. How to invoice
  Attachment 6 1150 Waiver request
  Attachment 7 Plan of care summary
  Attachment 8
  Attachment 9

1157-95-01 Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age

  Page 3, A(2)(c)
    A(4)
  Page 4, B, C, "To receive MA reimbursement"
  Page 5, D(1), (2), "Payment will be made only for services prior approved by OMAP"
  Pages 9-14, (A), (B)
  Attachment 2, 3(e), 4(b), 4(e)
  Attachments 5, 6, 7, 8, 9, 11
1165-95-01  **Update, JCAHO-Accredited RTF Services**
Page 3, The two paragraphs following item C
Page 4, The last paragraph in item 2, "All admissions are subject..."
  (3. HIO and HMO)
Page 5, Invoicing for RTF Services
Page 7, (b and c)
Page 10, Last sentence on the page

50-96-03  **Summer Therapeutic Activities Program**
p.3, 3rd paragraph - Reference to the maximum period of "five weeks per calendar year"

p.3, 4th paragraph - The required supporting documentation for the provision of this service does not apply except as required by the MCO of their provider network.

p.6, "Provider Requirements" - #1

pp.7-8, "Payment for Services"

Attachment 7

01-97-16  **“Change in Procedure for Requesting and Billing Therapeutic Staff Support (TSS) Services.”**

99-97-06  **“Accurate Billing for Units of Service Based On Periods of Time.”**

01-97-08  **“Diagnostic and Psychological Evaluations.”**

Page 2 – “The Department limits these procedure codes to three per child, regardless of the combination of procedure codes…to end of paragraph.”

01-98-19  **“Clozapine Support Services.”**

Page 3: “Non-covered services” #1, #3, #4 and #5
Page 3: 2nd paragraph “The maximum time period for each order shall not exceed 6 consecutive calendar months.”

Page 5: the entire chart.

99-98-12 “Accurate Billing for Units of Service Based on Periods of Time.”

01-98-10 “Change in Billing Procedure for Behavioral Health Rehabilitation Services.”

Page 2: “Discussion:”

01-00-01 “Expansion of Special Pharmaceutical Benefits Clozaril Program.”

“Background:” 1st Paragraph: “Reimbursement for special pharmaceutical covered drugs is processed… to the end of the third paragraph.”

28-97-06 “Change in Billing Procedures for Psychotherapy.”

28-99-03 “Increased Fees for Outpatient Psychiatric Clinics, Psychiatric Partial Hospitalization Programs and Outpatient Drug and Alcohol Clinics.”

17-99-02 “Procedures for Licensed, Enrolled Mental Retardation Providers to Access and Submit Claims for Outpatient Behavioral Health Services for Individuals Under 21 Years of Age.”

Page 2: Procedures: #2, #3 and #4.

Page 3: Procedure: #5

Page 3: “Procedure for Handling TSS, MT and BSC Services Already Approved Through the 1150 Administrative Waiver Process” #s 1, 2 and 3

1153-95-01: Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age.”

Page 5(c) (2): 3rd paragraph “A Provider Type 50 …. MA Bulletin.”
Page 4 (d): # and #2

Page 6 (a): #1 (a)

Page 8: #3 (a-c), note, #4, #5(a), #5 (b-e):
- #3 (a-c): “Requesting Exception to the Fee Schedule Rate”
- #4 – Pg. 8: “Notification of decision to approve or reject exemption request – Request for prior approval”
- #5a – Pg. 9: “Decision to approve or reject”
- #5b – Pg. 9: “Written notification of decision”
- #5c – Pg. 9: “Parent/Legal Guardian notice/right to appeal”
- #5d – Pg. 9: “OMAP obtaining additional information within the 21 day period.
- #5e – Pg. 10: “Outpatient service authorization request (MA97)

Page 7-8: #6 (a-e)

Page 8-9: #7 (a-d)

Page 9: #8, #9, B: “Invoicing for Outpatient Wraparound MH Services.”

Attachment #4 “Subcontract Agreement Form.”

Attachment #8 “Request for Expedited Outpatient Behavioral Health Services.”

Attachment #5 “Outpatient Service Authorization Request.”

19-99-04 “Prescriptions Not Received by The Medical Assistance Recipient.”

50-97-03 “Training for EPSDT Expanded Services Providers (Provider Type 50) on Completing Medical Assistance Invoices.”

01-94-01, Outpatient Psychiatric Services for Children Under 21 Years of Age:

1) Page 2 - "Exceptions" - The entire section.

2) Page 3 - "Note" - The entire section.

3) Page 3 - "Reminder" - "...and must be requested from the Office of Medical Assistance through the 1150 waiver process."
4) Page 3, "Requirements and Procedures" - First two paragraphs and number 1.

5) Page 4, Number 6 (a-c).

6) Page 5, The MA fee, type services and procedure code

7) Page 7, The MA fee, type services and procedure code

8) Page 9, The MA fee, type services and procedure code

9) Page 10, The MA fee, type services and procedure code

10) Page 12, The Limit, MA fee and "Limit of 3 per year of any combination of the procedure codes listed, type of service and procedure code."

11) Page 13, The Limit, MA fee and "Limit of three per year of any combination of the procedure codes listed above" do not apply, type of service and procedure code.

12) Page 15, Last paragraph - ".. by an 1150 Waiver Request (MA 325)."

THE DEPARTMENT OF HEALTH

Managed care plans are to adhere to all federal and state confidentiality regulations. Adherence must be to the most restrictive regulations.
COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of Cultural Competence Principles

Cultural Competence has long been an expectation of Pennsylvania's public mental health system. Included in the CASSP and CSP Principles from their inception, cultural competence has historically focused on the four traditionally underserved populations of African Americans, Latinos, Asian Americans and Native Americans. More recently, the Office of Mental Health and Substance Abuse Services (OMHSAS) in collaboration with the OMHSAS Cultural Competence Advisory Committee, has taken a broader view of culture. Recognizing the diversity that makes up Pennsylvania's population, Cultural Competence is viewed as inclusive of rural and urban populations, deaf persons, the Amish, groups of recent refugees and clusters of various ethnic populations that are scattered across the Commonwealth, as well as the traditionally identified populations.

The Department in its issuance of the Request for Proposals for the HealthChoices Behavioral Health Program recommends the implementation of Cultural Competence Principles by the Primary Contractor, managed care organization (MCO), its subcontractors and any associated provider networks.

It is the expectation that the implementation of Cultural Competence Principles will result in a system that understands the implications of racial genetics for medication prescription, the differences in help seeking behaviors among various groups and populations and the basis of internal and external stigma related to mental illness, as well as many other barriers to a successful and effective system of care.

PRINCIPLES OF CULTURAL COMPETENCE

1. Principle of the Universality of Ethnicity and Culture. Each person is aging therefore has an age and an age cohort. Each person has: a gender, therefore a gender orientation; abilities, therefore limitations; resources deriving from social constructs, therefore a socioeconomic status; a family history and a legacy that precedes by many generations, therefore an ethnicity and a culture. Identification with others by all these means helps provide a sense of security, belonging and identity. It is this power that drives “Honk if you own a Volkswagen”, or “the wave” at ball parks to work so effectively. Each human encounter in so far as it crosses some boundary of age, belief or practice is, in a sense, a cross-cultural encounter, but we have many bridges to facilitate the crossing. Culture is more than just membership in one’s racial/ethnic group. Culture is a dominant...
force arising within us from our parental and community upbringing, serving to shape behavior, values, cognition and social institutions.

In the treatment setting, every consumer must be valued within his/her cultural context. Observed differences are to be appreciated as sources of strength and enrichment and resources of reconnection and reintegration. Within each individual’s thinking, personal history and family culture lay the defining attributes of his or her problems and the solutions. The wholeness of the individual is important for a complete evaluation and effective intervention.

2. Principle of Cultural Competence. Treatment, recovery and rehabilitation are more effective when consumers and families fully engage in services that are compatible with their cultural values and world-views. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people (Child and Adolescents Services Systems Program Principles). These skills are used to determine consumer wellness/illness, establish individualized and consumer-driven plans and goals, and to create unique services that are community-based and that integrate natural supports. Cultural competence entails knowledge of consumers’ literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. This body of knowledge guides the service system to increase consumer access to services, and to better design, implement and evaluate services tailored to particular cultural groups. The principle entails vigorous integration of cultural competency principles and standards of practice throughout all levels of behavioral health and substance abuse planning, policy-making, research, evaluation, training and service delivery.
3. Principle of Social and Environmental Influences. Social conditions of poverty, unemployment, discrimination, class rank, immigration status, and isolation greatly impact all aspects of behavioral health care, and contribute deleterious effects and exacerbate symptomatology. Effective service outcomes and quality of life are achieved when the consequences of these social experiences are identified and incorporated into health care planning and service delivery. Services are designed and funded to assure these conditions are not barriers to health care. The service system assures that services do not merely reach the most motivated, educated and socially mobile consumer and family. Service evaluations entail assessing the prevalence of these social conditions in communities, and engaging consumers at the highest risk of illness. Planning processes recognize social conditions and their impact on health and interventions. Professionals avoid assigning fixed diagnoses and characteristics to consumers who are merely responding to stressful social conditions. Service systems adopt no-reject/no-eject standards of practice so that no consumer is rejected or ejected from services because of behavior that is necessary to survive and cope in their social conditions.

4. Principle of Consumer-Driven Services. Consumer-driven services include activities that individualize plans, assessments and services that focus on the priorities, values and goals of consumers and families. Whenever possible, self-help services are created and utilized. Consumer-driven services foster self-determination and choice. Cultural groups are fully engaged when they are actively involved in the design, implementation and evaluation of services that fit their unique worldview. For many cultural groups this entails services that heal the wounds of bias and discrimination. It entails the establishment of linguistically appropriate services, assuring the availability of culturally competent advocates, and educating consumers on the workings of the service system. Consumers, and their families and communities, fully participate in determining the kind of services that best achieve goals for achieving high quality and meaningful lives. Systems of care must have a goal of empowering consumers, during the course of treatment, to be self-determining in all domains of their lives.

5. Principle of a System of Care. Systems of care are consumer-driven, highly coordinated service responses to multiple needs of consumers and families. They require professional willingness to engage, interact and communicate in effective partnerships with culturally diverse populations, and to encourage and value consumers’ active role in the service planning process. In a system of care services focus on all domains of consumers’ lives (mental health, education, medical, housing, social rehabilitation, employment) and integrate health care needs into a single coordinated plan of services that is individualized and culturally relevant. Services are community-based, involve natural supports, strength-based, and are least restrictive. Cultural and non-traditional ways of healing are integrated in case management and treatment/rehabilitation plans. All planning processes are consumer-driven and family-focused. Family and community members are engaged and invited into the planning and service delivery processes. This entails planning meetings that are community-based and are convenient to consumer availability. These strength-based, comprehensive plans are designed to enhance consumers achieving high quality and meaningful lives.
6. **Principle of Access.** Access occurs when cultural groups perceive that services are relevant to their life experience and world-view, and use them. Linguistic, geographic and cultural barriers to services are identified and removed. Service systems use culturally relevant media to inform and educate cultural groups, and the general public, about services and supports. Full access to services is determined by evaluating both the use of services by cultural groups as compared to the general population, and by evaluating the prevalence of concerns and problems in specific cultural communities. Increasing access results in less use of crisis and emergency services. Problems and concerns are identified early, and prevention and support services reduce the severity and prevalence of chronic illnesses. This principle entails identifying and overcoming transportation, poverty and community safety barriers to services. Whenever possible, services are community-based.

7. **Principle of Quality of Life Outcomes.** Consumers and families evaluate outcomes of services, and the service system, by their ability to enhance and improve quality of life. Quality of life is achieved when consumers reach and accomplish self-defined meaningful life goals. It involves having meaningful social roles within family and community. It involves consumer empowerment and self-determination to make decisions in all domains of their life. Case management and treatment/rehabilitation plans encompass all domains of consumers’ lives to foster growth and development of necessary personal, social, employment and interpersonal skills to achieve fulfillment and wellbeing. Holistic approaches to health care are essential to assure consumers have a high quality of life.

8. **Principle of Managed and Integrated Health Care.** Costs of public health care are best managed and contained by providing high quality, effective mental health and substance abuse services tailored to consumers and family culture that integrate and coordinate medical, mental health and substance abuse. In this way, consumer engagement may be maximized, and use of more costly emergency services reduced. Primary health care that engages consumers in preventative health care throughout life development reduces costs and improves the overall health of our communities. Integrating physical and emotional health in assessments, plans and services is essential. The service system emphasizes managing care, and not dollars, by assuring consumers are in least-restrictive treatment settings, and gain access to services early.

Prevention is a key goal for managed and integrated systems of care. Prevention includes community education about mental illness, substance abuse, family support services, early identification programs and services, and social marketing campaigns to de-stigmatize mental illness. Prevention and early intervention necessitate behavioral health providers to link with physical health care providers and other community-based services. Assuring a high quality of life for consumers is considered an important aspect of prevention. Subsequently, increasing community employment and job skill training are examples of prevention activities.
9. **Principle of Data/Evaluated Driven Systems of Care.** Traditional ways of collecting information, and planning and evaluating services, do not reach isolated and high-risk populations. Many existing information systems and planning processes do not attain information about communities, and only focus on those currently and traditionally served. Assuring services are culturally competent requires engaging communities to gather information about the prevalence of problems, stressful social conditions, substance abuse and mental illness. Data and findings are always interpreted in the context of each cultural community, and not merely compared to the general population as a normative standard. Individual, family and community outcomes are projected as an aspect of county planning processes. Storytelling, testimonials, and oral accounts of needs and satisfaction are considered data sources. In consumer-driven systems of care, feedback by consumers regarding service satisfaction and outcome are most important data for future planning and system re-design.

Outcomes and effectiveness of services are evaluated based on the prevalence of illness and problems in the cultural community, and not merely by comparing rates to the general population. This principle assures professionals and community members avoid using the dominant culture as a normative standard of health. Rates of illness are impacted by cultural, social and historic differences among social groups. Behavior that seems aberrant to the general population may be healthy responses to social conditions. Services target the unique patterns of illness and problems in cultural communities, and develop unique community-based health standards by which to evaluate services.

10. **Principle of Least Restrictive/Least Intrusive Services.** Services occur in settings that are the most appropriate and natural for the consumer and family, and are the least restrictive and intrusive in impacting the right of self-determination by consumers, families and communities. (CASSP) This means community-based, in-home and natural support services being first utilized, unless there are assessed indications that other services are necessary to assure outcomes and quality of life. Justification for more restrictive and intrusive services occurs at all levels of planning: initial assessment through discharge. Consumer, family and community members are included in determining the least restrictive/intrusive setting and service. As minorities are over-represented in restrictive settings, and as recipients of behavioral controlling treatments, service systems regularly collect data and monitor these services. Plans of action are created and implemented when evaluation finds cultural groups are over-represented in restrictive treatments.
GUIDELINES FOR THE APPLICATION OF CULTURAL COMPETENCE PRINCIPLES

ACCESS AND SERVICES AUTHORIZATION

Families and natural supports persons (self-defined family) have access to services in a respectful and welcoming manner. Services are provided in timely, convenient and easily accessible ways. Protocols exist to assure services are available to persons who are disinclined to accept treatment. Bilingual and bicultural providers, and trained interpreters, are available throughout the entire service system. Service availability and determination encompass a holistic rehabilitative approach that includes psychiatric, medical, social, vocational, behavioral, cultural, spiritual, familial and community supports.

Indicators of Guideline Application

1. Persons of diverse cultures and linguistic differences are served based on their preference and actual need.

2. Service systems utilize a variety of formats to disseminate culturally relevant information regarding mental health and addiction services, as well as non-traditional and self-help resources.

3. A written plan guides action that engages and encourages individuals in need of services but who are disinclined to accept treatment.

4. Service systems demonstrate timeliness in member access and authorization of services.

5. Service systems adopt flexible service hours to maximize the availability of services.

6. Service systems authorize cultural-based alternative and complementary treatment approaches that assure consumer engagement, retention and follow-up.

7. Service systems staff and Managed Care Organizations have culturally and linguistically competent staff available 24 hours a day, and 7 days a week.

8. Service agencies have a milieu and physical environment that reflects diversity and the surface cultures of consumers being served.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization rates of traditionally under-served and over-represented persons are comparable to the prevalence of illness and problems that occur in the ethnic/cultural group. Cultural/ethnic community residents use behavioral healthcare providers as a community resource for all health concerns. In highly
2. restrictive services, utilization rates are comparable to all other groups in the general population.

3. Service providers have a list available in each facility of culturally and linguistically accessible services.

4. Descriptions of culturally sensitive services and programs are available for consumers in their community and other natural gathering places. Providers develop ethnically/culturally relevant ways of disseminating information that make services widely known in ethnic/cultural communities.

5. Educational and information materials reflect the languages and cultures of persons served.

6. Service systems track the utilization rates of persons who are traditionally disinclined to accept treatment. These systems develop studies on the prevalence of illness and problems in ethnic/cultural communities, and identify the barriers they experience to seeking help. Service systems create correction plans, implements actions, and measure improvements in help-seeking behavior. Indicators of positive impact include: decrease use of emergency rooms, decrease use of crisis services, increase number and use of advocacy groups, decrease arrest rates of persistently ill consumers, increase referral follow-through rates, and increase voluntary use of self-help and prevention services.

7. Service systems track the increase in availability of services. Availability is indicated by services occurring in settings that various ethnic/cultural groups define as comfortable, appropriate, consistent with their values and worldview, and complementary to their natural healing practices.

8. Service systems track the number and type of alternative and complimentary treatment approaches for various cultural groups. High performance is indicated by an integration of traditional healing practices and treatment approaches with professional models that capture the best of each.

9. Service systems determine consumer satisfaction and increase access because of flexible hours, and alternative and complimentary treatment.

10. Waiting area and offices display magazines, art, music, etc., reflective of the cultures and ethnic groups of consumers being served.
CASE MANAGEMENT

Case management shall be central to the operation of the multidisciplinary team. It reflects an understanding and appreciation of the values, norms and beliefs of consumers’ cultures, and knowledge of resources in their communities. Case management recognizes the unique mental health/substance abuse issues associated with the consumer’s economic conditions, social class, and experience of bias, discrimination and racism. Case management recognizes the impact of these issues on behavioral health, and takes these into account in considering the cultural appropriateness of all services that are coordinated and managed. Case management advocates for the consumer, assures consumers are knowledgeable of service options, and assists consumers in making best choices. These activities are individualized to the diverse culture, race, ethnicity and language differences. Case management services participate in ongoing assessments of their service system to determine and assure that they are responsive to diverse consumer needs and experiences.

INDICATORS OF GUIDELINE APPLICATION

1. Consumers have access to a comprehensive array of services that are compatible with their culture.

2. Consumers receive culturally competent services that are coordinated within multiple domains, i.e., vocational, social, educational and residential settings.

3. Culturally competent services are continually created and adapted to meet the needs of consumers.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization data and information are utilized to increase enrollment of underserved populations. Ethnic cultural group enrollment in less restrictive services (outpatient, self-help, social rehabilitation) increases to levels comparable to the general population. Enrollment in restrictive services (inpatient, involuntary commitments, jail treatment settings, court-ordered outpatient) decreases to levels comparable to the general population.

2. Service systems document culturally competent services and resources received by consumers. Individual and family definitions of culture, ethnicity and need guide the development of indicators for high levels of performance. Merely providing culturally competent services to persons of color, or persons who are perceived different than mainstream culture, is not an indicator of compliance.
3. Service systems document family and community contacts/visits, and visit locations. High levels of compliance are system-wide supports for family and community member advocacy and full participation in all aspects of case planning. Parent led support/advocacy groups naturally develop and influence decision-making throughout the delivery system. Merely having record of family member attendance at meetings is not an indicator of compliance.

4. Service systems document that consumers have improved relationships within family, and within social networks of their cultural group. High levels of compliance are indicated by fewer consumers estranged from their natural family, and high levels of family involvement in planning processes and support services.

5. Service systems document that consumers achieve the greatest degree of independence and self-determination. The use of restrictive services by ethnic/cultural groups is reviewed annually for use in comparison to the general population. Each provider implements a plan of correction until usage levels are comparable. Restrictive care includes the use of psychotropic treatment without complementary clinical/rehabilitative services.

6. Revised care plans and services demonstrate inclusion of ethnic, social and cultural factors.

7. Cultural competence training for all case managers is incorporated in reviews for regulation compliance. Training is designed for the ethnic/cultural groups that exist in the service community. Levels of training and competence are established.

8. Community resources and natural supports are included in all care plans.

**TREATMENT / REHABILITATION PLAN**

All persons served receive a treatment/rehabilitation plan that is holistic, and incorporates the consumer's choice of attainable goals, culturally compatible treatment modalities, and consumer driven alternative strategies of health care. These strategies include the use of family, community supports, spiritual leaders and folk healers. Plans are consumer driven, based on their individual strengths, and developed within the context of family and social networks so as to create a consumer-professional partnership. Plans are formulated and reviewed by culturally competent professionals and culturally competent consultants in full collaboration with consumers and families.
INDICATORS OF GUIDELINE APPLICATION

1. Identification and creation of culturally relevant goals.

2. Use of culturally compatible modalities and alternative strategies.

3. Consumers and families fully participate and share in the development of goals and wishes, and express satisfaction with their role and participation.

MEASURES OF GUIDELINE APPLICATION

1. Plans document consumer wishes and goals. These may be related to employment, education, training, personal appearance, health, family relationships, social activities and social relationships. Plans specify ethnically/culturally relevant wishes and goals.

2. Service systems document consumer and family satisfaction with their participation in the treatment/rehabilitation planning process. Low levels of satisfaction trigger plans of correction, implementation of these plans, and re-evaluation.

3. Plans outline cultural relevant treatment and rehabilitation modalities and strategies.

4. Service systems document that professionals are trained in the development of culturally competent treatment and rehabilitation plans. Training, staff skills, and cultural competence will be greatly impacted by the kinds of ethnic/cultural groups in the service area. A high level of performance is indicated by professional standards for competence for each ethnic/cultural group, and not a generalized declaration of professional competence due to completion of a generalized cultural competence training program.

5. Service systems create all written planning materials and documents in plain and simple text that is readily comprehended by consumers and families.

RECOVERY AND SELF-HELP

Recovery and self-help groups are readily available, and function as an integral part of a seamless continuum of care. Recovery and self-help groups are culturally diverse and culturally compatible, incorporating consumer-driven goals and objectives that are oriented toward rehabilitation and recovery outcomes. Culturally competent providers and consumers in recovery are enlisted as consultants and educators to assist in the creative development of alternative treatment services, models and supports that are compatible with the lifestyles, values and beliefs of various cultures.
INDICATORS OF GUIDELINE APPLICATION

1. Services are accessible and available in a variety of settings, including churches, neighborhood facilities, and consumer residences.

2. Service system creates more integrated, culturally and linguistically specific, recovery groups.

3. Services are readily accessible and available in a variety of settings.

4. Community groups, consumers in recovery and other natural supports groups are recruited in the development and design of recovery and self-help service models.

MEASURES OF GUIDELINE APPLICATION

1. Service systems document the increase use of recovery and self-help programs by consumers of various cultural groups. As families and communities are engaged in services, the number of ethnic/cultural self-help, advocacy and recovery groups increase. A high-level of self-determination which is emphasized while maintaining inclusion in the service system is a strong performance indicator.

2. Service systems document an increase in the variety of ethnically/culturally relevant recovery and self-help programs. The array of ethnic/cultural services increases as the service system better engages and empowers families and communities.

3. Providers make available to consumers a list of recovery and self-help services in locations that are readily accessible to consumers and their communities.

CULTURAL ASSESSMENT

A cultural assessment is conducted by competent staff for each consumer, and within the context of the consumer's culture, family and community. The assessment is individualized, multidimensional and strength-focused. The components of the assessment include functional, psychiatric, social status, cultural milieu, social and economic stresses, discrimination, and family supports.
INDICATORS OF GUIDELINE APPLICATION

1. A cultural assessment is the basis for a culturally relevant diagnosis, goals and rehabilitation/treatment plans.

2. A cultural assessment tool and guide exists to determine cultural factors that impact treatment/rehabilitation services.

3. On-going cultural assessment occurs at each phase of treatment and rehabilitation.

4. Cultural assessment includes consumer preferences, and differentiates pathology from cultural factors.

MEASURES OF GUIDELINE APPLICATION

1. Bilingual staff is available to assess consumers in their language of preference.

2. Qualified cultural interpreters are utilized when bilingual staff is not available.

3. Psychological assessment and measurement tools are culturally valid and reliable, and administered, scored and interpreted by culturally competent providers.

4. All consumers receive an ethnic/cultural assessment. The rates of chronic, anti-social and other serious diagnoses for all ethnic/cultural groups are comparable to the general population. The use of restrictive treatments for all ethnic/cultural groups is comparable to the general population.

5. Providers document the inclusion of family members and significant community support persons in the initial and on-going assessment process. An indicator of high level performance is community-based, including community/family/consumer driven assessments and service planning.

6. The assessment includes cultural factors that are important to the treatment process. These factors include, but are not limited to, the following:

   a) Preferred language.
   b) History of indigenous/immigration/migration/generation behavior patterns.
   c) Degree of acculturation and adaptation.
   d) Cultural, social, economic and discrimination stresses and traumas.
   e) Learning and cognitive styles.
f) Family organization and relational roles.
g) Extent of family support.
h) Social network composition.
i) Ethnic identity
j) Consumer’s perception/belief of presenting problems and explanations for symptoms.
k) Consumer’s belief systems regarding mental illness/substance abuse.
l) Sexual identity and sex role orientation in cultural group.
m) Coping strategies utilized within the cultural group.
n) Help-seeking behavior.
o) Previous attempts at relieving, managing and treating symptoms. (Including healers, traditional medicine, etc.)

To protect the rights and confidentiality of consumers, family and friends are not to be used as language/communication interpreters. These persons are welcomed to participate in the treatment planning process.

**COMMUNICATION STYLE AND LINGUISTIC SUPPORT**

Consumers, families and other support persons receive cross-cultural and communication-support, such as assistive devices and qualified language interpreters and professionals interpreters. These supports are available at each entry point to services, and continue throughout the consumer’s treatment and rehabilitation services. Staff is knowledgeable in the use of professional interpreters, and telephone interpreters are only utilized in emergencies. Orally presented information, and written materials and documents, are translated in the consumer’s preferred language. Examples include consumer rights information, orientation packets, consent forms and treatment plans.

**INDICATORS OF GUIDELINE APPLICATION**

1. Consumers and family members receive cross-cultural communication supports at each point of entry in the service system.

2. Consumers and family members report their level of satisfaction with communication supports.

3. Staff is knowledgeable in the use of communication supports.

4. Interpreters are qualified, competent, and demonstrate knowledge of consumers’ cultural experience; including deaf, hard of hearing, and deaf blind.
5. Communication supports demonstrate culturally accurate assessments, treatment/rehabilitation plans and service delivery.

6. Cross-cultural communication supports are available and comparable across all consumer cultural groups.

MEASURES OF GUIDELINE APPLICATION

1. Service systems increase the number of bicultural and bilingual staff, competent in the communication styles of the diverse cultures of consumers, as to minimize the use of interpreters.

2. A resource list of trained and qualified interpreters, updated annually, is maintained by facilities. Consumers and families are aware of the availability of interpreters through service advertisement efforts.

3. Certified qualified interpreters are available within 24-hour notice for routine situations, and within one hour for emergencies.

4. Service systems document consumer satisfaction of communication supports. A plan of correction and implemented action occur when consumer are not satisfied with communication supports.

5. Service systems document that staff receives training in the use of interpreters.

6. Service systems document that interpreters are certified (sign language interpreters), qualified and competent.

7. Service systems document that communication supports are comparable across consumer cultural groups.

CONTINUUM OF SERVICE/DISCHARGE PLANNING

Service and discharge planning begin at all points of entry along the continuum of services. It is provided by culturally competent providers in cooperation and collaboration with consumer, family, community support persons, and persons in consumer social networks. Service and discharge planning are done consistent with the values, norms and beliefs of consumers. These plans incorporate pertinent information from the cultural assessment, and include service/discharge factors that are culturally relevant and important to the consumer’s recovery.
Plans identify personal, family, social environment, social network and cultural resources necessary for treatment and rehabilitation services that assure consumer recovery.

**INDICATORS OF GUIDELINE APPLICATION**

1. A culturally compatible continuum of service/discharge plan is developed for each consumer.

2. Plans include clear goals and recommendations for necessary services in the post-discharge continuum of care.

3. Plans use the resources of family and social networks.

4. Plans assure consumers remain connected to treatment/rehabilitation recovery services as needed.

**Measures of Guideline Application**

1. Service systems document service/discharge plans involve consumers, family members, community resources, and social supports. High levels of performance occur when family and community members are partnered with consumers and driving the planning process. Family and community members merely attending meetings is not an indicator of adequate performance.

2. Plan lists the resources and services utilized, and consumer accomplishments.

3. Consumer values, norms and beliefs are documented in the plan and drive the planning process.

4. Service systems document future treatment and rehabilitation goals.

5. Service systems document recommendations for the use of consumer, family, social networks and cultural resources in any subsequent treatment/rehabilitation setting.

**QUALITY OF LIFE**

Quality of life is achieved through a holistic integration of symptom reduction, family and community support, and spirituality, which maximizes the consumer’s sense of personal meaning, fulfillment and well-being. Assuring consumers have a high quality of life enhances recovery. Quality of life is determined by an individual’s freedom to make choices and enjoy the benefits of those choices.
INDICATORS OF GUIDELINE APPLICATION

1. Service system develops ways of assessing the quality of life for all consumers.
2. Consumers report improved quality of life through services.
3. Consumers direct the recovery planning and treatment process.

MEASURES OF GUIDELINE APPLICATION

1. Assessments, treatment/rehabilitation plans and services incorporate the goals, preferences, hopes and wishes of consumers.
2. Service systems compile, collect and interpret quality of life measures.
3. Service systems utilize quality of life information and data to evaluate and improve service delivery, and to develop new services.

SERVICES ACCOMMODATIONS

Programs respond to the needs of individuals and families from different cultures by ensuring the best cultural fit between persons’ beliefs, their cultural/behavioral styles and the services provided. Based on information derived from cultural assessments (re: family styles, gender roles, sexual orientation, spirituality/religion, worldview, traditions, work ethic, communication styles, leadership and organizational styles cognitive and learning styles) services, interventions, modalities, and strategies are adapted or developed in order to better promote program engagement, treatment/rehabilitation, and retention. Particular consideration is given to the visible presence of different cultures throughout the program’s physical environment. Culturally competent strategies are utilized to attract and recruit consumers and families. Varied induction methods that orient persons to types of services offered as well as how to utilize and participate in these services are available. Service outcome expectations as well as clarification of both staff and consumer roles and responsibilities are reviewed.

INDICATORS OF GUIDELINE APPLICATION

1. Program services interventions and modalities are modified and developed in order to enhance consumer engagement, treatment/rehabilitation, or retention.
2. Varied program induction methods are available.
3. Varied outreach and recruitment strategies are utilized.
Measures of Guideline Application

1. Information derived from cultural assessments is collated and summarized.

2. Programmatic needs to ensure responsiveness to persons from different cultures have been identified and prioritized.

3. Selected, prioritized services, interventions and modalities that have been modified are documented.

4. Examples of varied culturally compatible, program outreach and recruitment strategies are documented.

5. Examples of varied program induction methods utilized to engage consumers and families from different cultures are documented.
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**Program Standards and Requirements: (PS&Rs)**

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**Behavioral Health Data Books**

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**Behavioral Health Program Audit Guide**

| 19c | Pennsylvania HealthChoices Behavioral Health Program Audit Guide for Audits of the Program Year 2010, Department of Public Welfare. *(When Available)* | ✔️      | ✔️      |

**MIS Reporting Requirements**

| 20 | **HealthChoices Behavioral Health MIS Reporting Requirements:** |
|    | a. Transition Monitoring – Manual 1 |
|    | b. Quarterly Monitoring/Early Warning – Manual 2 |
|    | c. Complaints and Grievances – Manual 3 |
|    | d. Consumer Registry File/Quarterly Status File – Manual 4 |
|    | e. Aggregate Reinvestment – Manual 5 |
|    | f. MCO Provider File – Manual 6 |
|    | g. Denial Log System Reporting – Manual 7 |
|    | h. PROMISe Transfer File Protocol (FTP) |

**Complaints and Grievances**

| 21 | **HealthChoices Behavioral Health Complaint, Grievance and Appeal Materials Handbook:** |
### Library/Internet Desk Reference Chart
**HealthChoices Behavioral Health Program**

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### Readiness Assessment Instrument and Deliverables

<p>| 22  | HealthChoices Southeast Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | ✓ |
| 23  | HealthChoices Southwest Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | ✓ |
| 24  | HealthChoices Lehigh/Capital Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | ✓ |
| 25a | HealthChoices Northeast #03-02 Draft Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. NBHCC | ✓ |
| 25b | HealthChoices Northeast #03-02 Draft Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. RSI | ✓ |
| 25c | HealthChoices Northeast Expansion #18-05 Draft Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | ✓ |
| 26  | HealthChoices North/Central State Option #02-06 Draft Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | ✓ |
| 27  | HealthChoices NC County Option Zone #10-06 Draft Readiness Assessment Instrument (RAI), and Readiness Review Deliverables List. | |
| 28  | MH Statutes, Regulations, and Guidelines: (<a href="http://www.pacode.com">www.pacode.com</a>)               |         |         |
| a.  | PA Code Title 55, Chapter 5100; Mental Health Procedures <a href="http://www.pacode.com/sec">http://www.pacode.com/sec</a>... | ✓ | ✓ |</p>
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### HealthChoices Behavioral Health Program

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<td>Medical Assistance Bulletin #17-02-04, 41-02-04, 11-02-04, 12-02-03, 01-02-11, 50-02-03, 53-02-01, 13-02-02, Residential Treatment Facility Services Provided in a Secure Setting.</td>
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<td>Methadone, when used to treat narcotic/opioid dependency and dispensed</td>
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### CASSP Principles:

**Children’s Mental Health Services: CASSP Support Information:**
[http://www.PARecovery.org](http://www.PARecovery.org)

- a. “Attention Deficit Hyperactivity Disorder and Stimulant Medication”.
- c. Continuous Quality Improvement in Family-Based Mental Health Services.
- d. Enhancing Family-Professional Partnerships.
- f. How to Think, Not What to Think (A Cognitive Approach to Prevention of Early High-Risk Behaviors in Children.
- g. Implementing Comprehensive Classroom-Based Programs for Students with Emotional and Behavioral Problems.
- h. “A Mental Health Practitioner’s Guide to Positive Behavior Support for Children with Disabilities and Problem Behavior at School”.
- i. Mental Health Residential Treatment Facilities within the Continuum of Child and Adolescent Mental Health Services.

CASSP Web ✔️
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<td>j.</td>
<td>A Model for Multi-System Service Planning Meeting.</td>
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<td>“Parent Participation in the Residential Treatment Process”.</td>
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<td>m.</td>
<td>Pennsylvania’s Ideal Child Mental Health System Design (A CASSP Concept Paper).</td>
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<td>Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs.</td>
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<td>Putting It Together: Providing Mental Health Services in Early Intervention.</td>
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<td>Residential Services (The Perspective of an African American parent).</td>
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<td>q.</td>
<td>“Therapeutic Staff Support in Professional Practice”.</td>
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<td>To Walk In Troubling Shoes: Another Way to Think About the Challenging Behavior of Children and Adolescents.</td>
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<td>What Makes Wraparound Special: (Understanding and Creating a Unique Experience for Children and Their Families).</td>
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<td>Writing Effective Treatment Plans (The Pennsylvania CASSP Model).</td>
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34 **CSP Principles**

**Adult Mental Health Services: Community Support Information:**

| a. | What is CSP, History, Principles, CSP Wheel, Components | ✓ |
| b. | Local CSP Committees; What Do They Do?                  |   |
| c. | The CSP Program in Pennsylvania.                        |   |
| d. | Statewide Community Support Program Advisory Committee. |   |
| e. | An Ideal Mental Health Service System.                   |   |
| f. | Pennsylvania Drop-In Centers.                           |   |
| i. | National Alliance for the Mentally Ill of Pennsylvania, (NAMI of PA). |   |
| j. | Community Support Systems for Persons with Long-Term Mental Illness (Questions and Answers). |   |

35 **Pennsylvania Regulations Continued: (Regulation Booklets)**

<p>| a. | PA Code Title 55, Chapter 2380; Adult Training Facilities | ✓ | ✓ |
| b. | PA Code Title 55, Chapter 2390; Vocational Facilities    | ✓ | ✓ |</p>
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<td>Public Law 103-227; The Pro-Children Act of 1994</td>
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36 Provider Types and Licensed Programs:

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<td>PA Department of Health, Bureau of Drug and Alcohol; Pennsylvania Drug and Alcohol Facility and Services Directory, 2005</td>
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<td>Most Current Behavioral Health Services Reporting Classification Chart (<a href="http://dpwintra.dpw.state.pa.us/OMHSAS/news/sysnews.asp">BHSRCC</a>), July, 22, 2006.</td>
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### Cultural Competency:

| A | The Pennsylvania Office of Mental Health and Substance Abuse Services Strategic Plan for Cultural Competence. | ✓       |
| B | Recommended Clinical/Rehabilitation Standards of Practice for Culturally Competent Services in Pennsylvania. | ✓       |

### Miscellaneous Information:

| a | Act 68 – Managed Care Consumer Protection Act (1/1/99) | ✓       |
| b | Provider Type 80 Enrollment | ✓       |
| c | Statewide Mandatory Medicaid Managed Care Summary (October 1997) | ✓       |
| d | HealthChoices “Next Steps” Paper; Top Comment Areas | ✓       |
| e | North Central Zone Discussion Paper (January 2001) | ✓       |
| f | Disadvantages Businesses/Enterprise Zone Small Business ([http://www.dgs.state.pa.us/bcabad/cwp/view.asp?a=3&Q=122384](http://www.dgs.state.pa.us/bcabad/cwp/view.asp?a=3&Q=122384)) | ✓       | ✓     |
| g | Protocol to Review Formularies | ✓       |
| h | Pro-Children Act of 1994 (Smoking in Children’s Facilities Prohibition) | ✓       |
| i | HealthChoices Behavioral Health Services: Overview, Oversight, Eligible Recipients, Enrollment, Services provided, County Mental Health System, and Drug and Alcohol Service. | ✓       | ✓     |
| j | POSNet OIS Circuit Ordering & Billing Authorization Form | ✓       | ✓     |
| k | OMHSAS QUIC Facts 2010 ([http://www.PAreccovery.org](http://www.PAreccovery.org)) | ✓       | ✓     |
### Library/Internet Desk Reference Chart
#### HealthChoices Behavioral Health Program

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<td>a. Medical Necessity Criteria and Standards</td>
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<td>b. US Psychiatric Rehabilitation Association Core Principles and Values. (USPRA)</td>
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<td>c. Guidelines for requests for Admission, Continued Stay and Discharge (2nd Edition)</td>
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<td>This CY 2001/2002 report can be used by consumers, families and persons in recovery to learn how well the mental health and drug and alcohol system is working.</td>
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**HealthChoices Behavioral Health Program**

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<td>Healthy Planning to Stay Calm in an Emergency - Basic Emergency Checklist&lt;br&gt;Provides a List of Items Needed For an Emergency Kit.</td>
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<td>HIPAA Authorization for Use or Disclosure of Personal Information form&lt;br&gt;English and Spanish version of the fill-in form used to authorize the Department of Public Welfare in the use/discloser of an individual's personal information.</td>
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<td>National Association of the Deaf&lt;br&gt;National Association of the Deaf Position Statement on Mental Health Services for People who are Deaf and Hard of Hearing.</td>
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<td>8</td>
<td>SAMHSA Mental Health Transformation Trends: A Periodic Briefing&lt;br&gt;An Online SAMHSA Publication that Focuses on Mental Health Transformation</td>
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<td>Office of Medical Assistance (OMAP) Fee Schedule and PROMISe FAQs</td>
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<td>✔ Provider Type Specialties Crosswalk</td>
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<td>✔ MAMIS Fee Schedule 2/1/04, for Reference Only</td>
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<td>✔ Frequently Asked Questions for Medical Assistance Providers</td>
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<td>“Frequently Asked Questions”, 2004</td>
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<td>Medical Assistance Eligibility Handbook:</td>
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<td><a href="http://www.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ma/Index/MA_Index-02.htm#P274_1976">http://www.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ma/Index/MA_Index-02.htm#P274_1976</a></td>
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<td>Medicaid Health Plan Employer Data and Information Set (HEDIS)</td>
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<td>Unavailable. Can be purchased on the NCQA Web Site at <a href="http://www.ncqa.org">www.ncqa.org</a></td>
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