

Utah Medicaid
Central Utah Counseling Center
Contract

Prepaid Mental Health Plan (PMHP)

Effective: July 1, 2021 (SFY 2022)

Attachment A - Utah Department of Health General Provisions

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UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS – NON RFP

I. CONTRACT DEFINITIONS

The following definitions apply in these general provisions:

"Assign" or "Assignment" means the transfer of all rights and delegation of all duties in the contract to another person.

"Business" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or any other private legal entity.

"This Contract" means this agreement between the Department and the Contractor, including both the General Provisions and the Special Provisions.

"The Contractor" means the person who delivers the services or goods described in this Contract, other than the state or the Department.

"The Department" means the Utah Department of Health.

"Director" means the Executive Director of the Department or authorized representative.

"Equipment" means an article of nonexpendable, tangible, personal property having a useful life of more than one year and an acquisition cost which equals the lesser of (a) the capitalization level established by the Contractor for financial purposes, or (b) \$5,000.00, unless a different definition or amount is set forth in the Special Provisions or specific Department Program policy as described in writing to Contractor.

"Federal law" means the constitution, orders, case law, statutes, rules, and regulations of the federal government.

"General provisions" means those provisions of this contract which are set forth under the heading "General Provisions."

"Governmental entity" means a federal, state, local, or federally-recognized Indian tribal government, or any subdivision thereof.

"Individual" means a living human being.

"Local health department" means a local health department as defined in § 26A-1-102, Utah Code Annotated, 1953 as amended ("UCA").

"Non-governmental entity" means a privately held non-profit or for profit organization not classified as a "governmental entity."

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"Person" means any governmental entity, business, individual, union, committee, club, other organization, or group of individuals.

"Recipient" means an individual who is eligible for services provided by the Department or by an authorized contractor of the Department under the terms of this contract.

"Services" means the furnishing of labor, time, or effort by a contractor, not involving the delivery of a specific end product other than reports which are merely incidental to the required performance.

"Special provisions" means those provisions of this contract which are in addition to the general provisions and which more fully describe the goods or services covered by this contract.

"State" means the State of Utah.

"State law" means the constitution, orders, case law, statutes, and rules, of the state.

"Subcontract" means any signed agreement between the Contractor and a third party to provide goods or services for which the Contractor is obligated, except purchase orders for standard commercial equipment, products, or services.

"Subcontractor" means the person who performs the services or delivers the goods described in a subcontract.

II. AUTHORITY

UCA 63G-6a-101 et. seq., UCA Titles 26 and 26A et. seq., and related statutes authorize the Department to enter into this Contract. The Contractor represents that it has the institutional, managerial, and financial capability to ensure proper planning, management, and completion of the project or services described in this Contract.

III. MISCELLANEOUS PROVISIONS

1. For reference clarity, as used in these General Provisions: "ARTICLE" refers to a major topic designated by capitalized roman numerals; "SECTION" refers to the next lower numbered heading designated by arabic numerals, and "SUBSECTIONS" refers to the next two lower headings designated by lower case letters and lower case roman numerals.

2. These provisions distinguish between two contractor types: Governmental and non-governmental. Unspecified text applies to both types. Type-specific statements appear in bold print (*e.g.*, non-governmental entities only).

3. Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in this Contract. Changes made to the unsigned Contract document shall be initialed by both persons signing this Contract on page one. Changes made to this Contract after the signatures are

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made on page one may only be made by a separate written amendment signed by persons authorized to amend this Contract.

4. Neither party may enlarge, modify, or reduce the terms, scope of work, or dollar amount in this Contract, except by written amendment as provided in section 4.

5. This Contract and the contracts that incorporate its provisions contain the entire agreement between the Department and the Contractor. Any statements, promises, or inducements made by either party or the agent of either party which are not contained in the written Contract or other contracts are not valid or binding.

6. The Contractor shall comply with all applicable laws regarding federal and state taxes, unemployment insurance, disability insurance, and workers' compensation.

7. To protect against liability, loss and/or expense in connection with the performance of services described under this Contract, the Contractor shall obtain and maintain in force during the entire period of this Contract without interruption, at its own expense, insurance as listed below from insurance companies authorized to do business in the State of Utah. If the solicitation document has qualification requirements for the financial stability of the insurance company, these requirements must be met.

The following are minimum coverages that may be supplemented by additional requirements contained in the solicitation for this Contract or provided in an Attachment to this Contract:

- (1) Worker's Compensation Insurance and Employers' Liability Insurance. Worker's compensation insurance shall cover full liability under the worker's compensation laws of the jurisdiction in which the service is performed at the statutory limits required by said jurisdiction.
- (2) General Liability Insurance. Contractor must carry insurance with policy limits no less than one million per incident and three million in the aggregate. Contractor must provide proof of insurance to State and must add State as an additional insured with notice of cancellation.
- (3) Professional liability insurance in the amount as described in the solicitation for this Contract, if applicable.
- (4) Any other insurance described in the solicitation for this Contract, if applicable.

Any type of insurance or any increase of limits of liability not described in this Contract which the Contractor requires for its own protection or on account of any statute, rule, or regulation shall be its own responsibility, and shall be provided at Contractor's own expense.

The carrying of insurance required by this Contract shall not be interpreted as relieving the Contractor of any other responsibility or liability under this Contract or any applicable law, statute, rule, regulation, or order.

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8. The Contractor is an independent contractor having no authorization, express or implied, to bind the Department to any agreement, settlement, liability, or understanding whatsoever, and agrees not to perform any acts as an agent for the Department except as this contract allows. Compensation as stated by this contract shall be the total amount payable to the Contractor by the Department. The Contractor shall be responsible for the payment of all income tax and Social Security amounts due as a result of payments received from the Department for these contract services.

9. The Contractor shall maintain all licenses, permits, and authority, as required by law and this Contract, necessary to accomplish its obligations under this Contract.

10. The Contractor shall obtain prior written Department approval before purchasing any equipment with Contract funds.

11. Notice shall be in writing, directed to the contact person on page one of this Contract, and delivered by certified mail or by hand to the other party's most currently known address. The notice shall be effective when placed in the U.S. mail or hand-delivered.

12. The Department and the Contractor shall attempt to resolve contract disputes through available administrative remedies prior to initiating any court action.

13. The laws of Utah construe and govern this Contract. The Contractor submits to the jurisdiction of the courts of Utah for any dispute arising out of this Contract or out of breach of this Contract. The proper venue of any legal action arising under this Contract shall be in Salt Lake City, Utah.

14. Any court ruling or other binding legal declaration which declares that any provision of this Contract is illegal or void shall not affect the legality and enforceability of any other provision of this Contract, unless the provisions are mutually dependent.

15. The Contractor agrees to maintain the confidentiality of records that it holds as agent for the Department as required by the Government Records Access and Management Act, UCA 63G-2-101 et. seq. and the confidentiality of records requirements of UCA Title 26 et. seq. The Contractor agrees that the Contract is a public document and may be available for distribution. Contractor gives the Department express permission to make copies of the Contract, related sales orders and invoices excluding client identifiable information, and the response to the solicitation in accordance with the Utah Government Records Access and Management Act. The permission to make copies takes precedence over any statements of confidentiality, proprietary information, copyright information, and similar notation.

16. The Contractor agrees to abide by Utah Executive Order 2006-0012, which prohibits all unlawful harassment in any workplace in which state employees and employees of public and higher education must conduct business.

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17. The waiver by either party of any provision, term, covenant or condition of this Contract shall not be deemed to be a waiver of any other provision, covenant, or condition of this Contract nor of any subsequent breach of the same or any other provision, term, covenant or condition of this Contract.

18. The right of the State to perform plan checks, plan reviews, other reviews and/or comment upon the services of the Contractor, as well as any approval by the State, shall not be construed as relieving the Contractor from its professional and legal responsibility for services required under this Contract. No review by the State or any entity /user, approval or acceptance, or payment for any of the services required under this Contract shall be construed to operate as a waiver by the State of any right under this Contract or of any cause of action arising out of the performance or nonperformance of this Contract, and the Contractor shall be and remain liable to the State in accordance with applicable law for all damages to the State caused by the wrongful acts, errors and/or omissions of the Contractor or its subcontractors or subconsultants at any tier, if any.

19. The Contractor agrees to warrant and assume responsibility for each hardware, firmware, and software product (hereinafter called the “product”) that it licenses or sells to the Department per this Contract. The Contractor acknowledges that the Uniform Commercial Code applies to this Contract. In general, the Contractor warrants that: (1) the product shall do what Contractor or a salesperson represented it would do; (2) the product shall satisfy all specific claims that the manufacturer or Contractor makes in advertisements; (3) the product shall be suitable for all ordinary purposes for which the product is ordinarily used; (4) if at the time of this Contract Contractor had reason to know of special purposes for which the Department required the goods and that the Department relied on Contractor's skill or judgment to select or furnish suitable goods, the product shall be suitable for the special purposes; (5) the product has been properly designed and manufactured; and (6) the product has no significant defects or unusual problems about which the Department has not been informed. Remedies available to the State include the following: The Contractor will repair or replace (at no charge to the State) the product whose nonconformance is discovered and made known to the Contractor in writing. If the repaired and/or replaced product proves to be inadequate, or fails of its essential purpose, the Contractor will refund the full amount of any payments that have been made. Nothing in this warranty will be construed to limit any rights or remedies the State of Utah may otherwise have under this contract.

20. The State of Utah’s sales and use tax exemption number is 11736850-010-STC. The tangible personal property or services being purchased are being paid for from State funds and used in the exercise of that entity’s essential functions. If the items purchased are construction materials, they will be converted into real property by employees of this government entity, unless otherwise stated in the Contract.

21. The parties may amend, modify, or supplement this Contract only by written amendment executed by the parties and attached to the original, signed copy of the Contract.

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22. Unless otherwise specified in this Contract, all deliveries will be F.O.B. destination with all transportation and handling charges paid by the Contractor. Responsibility and liability for loss or damage will remain with Contractor until final inspection and acceptance, when responsibility will pass to the Department, except as to latent defects, fraud and Contractor's warranty obligations.

23. The parties shall ship all orders promptly in accordance with the delivery schedule. The Contractor shall submit promptly invoices (within thirty (30) days of shipment or delivery of services) to the Department. The parties shall list the state contract number on all invoices, freight tickets, and correspondence related to the Contract. The prices paid by the Department shall be the prices listed in the Contract. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

24. The Contractor shall release, indemnify, and hold the State of Utah and the Department and all officers, agents, and employees of the State of Utah and the Department harmless from all liability of any kind or nature, including, but not limited to, the Contractor's use of any copyrighted or uncopyrighted composition, secret process, patented or unpatented invention, article, or appliance furnished or used in the performance of this Contract.

25. Neither party to this Contract shall be held responsible for delay or default caused by fire, riot, acts of God, or war which is beyond the party's reasonable control. The Department may terminate this Contract after determining that the delay or default will likely prevent successful performance of the Contract.

26. By signing this Contract, Contractor acknowledges that it understands that it is illegal for any person who is interested in any way in the sale of a procurement item (including, but not limited to, any supplies, services, and construction) or insurance to a public entity to give, offer, or promise to give anything of value, including, but not limited to, money, a loan with below-market rates or terms, an award, employment, admission to an event, a meal, lodging, travel, or entertainment for which a charge is normally made to anyone involved in the procurement process or the administration of a current contract or to an individual the person knows is a family member of anyone involved in the procurement process or the administration of the current contract, pursuant to Utah Code § 63G-6a-2304.5, as amended.

27. Any terms or conditions provided by Contractor that apply to this Contract must be in writing, attached to this Contract, and approved by both parties. No terms or conditions which are not in this Contract apply to this Contract, including, but not limited to, any terms listed or referenced on Contractor's website and any terms listed in Contractor's quotation or sales order. If there is any conflict between this Contract's terms or conditions, the order of precedence (listed in order of descending precedence) among the terms and conditions is: (1) Department General Provisions; (2) State of Utah Contract Signature Page(s); (3) Department Special Revisions; (4) Contractor Terms and Conditions.

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28. The Contractor agrees to maintain the security and integrity of any electronic media that contains confidential data procured or used pursuant to the undertaking of this agreement. At the termination of this agreement the Contractor shall certify in writing that all such confidential data has been disposed of in such a manner that it cannot be recovered or recreated. If, as part of this agreement, the Department has provided the Contractor with any type of electronic data storage device, the Contractor shall return all devices to the Department at the termination of this agreement.

29. If the Contractor is a nonprofit corporation, the Contractor shall comply with the following provisions. The Contractor shall disclose to the Department whether it received 50% or more of its funds from federal, state and local government entities through contract or that its revenues or expenditures total more than \$500,000 in the previous fiscal year. The Contractor shall disclose whether it anticipates receiving 50% or more of its funds from federal, state and local government entities through contract or that its revenues or expenditures total more than \$500,000 in the fiscal year the grant is issued. If the Contractor is a nonprofit entity, the Contractor shall comply with the Nonprofit Entity Receipt of State Money Act in Utah Code Ann. 63J-9-101 et seq. The Contractor shall provide the Department an itemized report at least annually detailing the expenditure of state money. The Contractor shall include provisions for the financial oversight of the state money and for the compliance with state laws related to state money, procedures to designate an administrator who manages the state money and a procedure to dismiss the designated administrator. The Department may require the grantee to return an amount of money that is equal to the state money expended in violation of the terms of the section.

IV. UTAH INDOOR CLEAN AIR ACT

The Contractor shall ensure that all its personnel operating within Utah comply with the Utah Indoor Clean Air Act (UCA 26-38-1 et seq.), which prohibits smoking in enclosed public places.

V. RELATED PARTIES & CONFLICTS OF INTEREST

1. As used in this section, “related parties” means any person related to the Contractor by blood, marriage, partnership, common directors or officers, or 10% or greater direct or indirect ownership in a common entity. The Contractor shall not pay related parties for goods, services, facilities, leases, salaries, wages, professional fees, or the like for Contract expenses without the prior written consent of the Department. The Department shall consider the payments to the related parties as disallowed expenditures and accordingly adjust the Department's payment to the Contractor for all related party payments made without the Department's consent.

2. The Contractor shall comply with the Public Officers' and Employees' Ethics Act, UCA 67-16-1 et seq., which prohibits actions that may create or that are actual or potential conflicts of interest. The Act also provides that, “No person shall induce or seek to induce any public officer or public employee to violate any provisions of this [Act]” (UCA 67-16-10). By signing this contract, the Contractor represents that none of its officers, directors, or employees are officers, directors, or employees of the State of Utah, besides any officers, directors, or employees properly disclosed per UCA 67-16-8.

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VI. OTHER CONTRACTS

1. The Department may perform additional work related to this Contract or award other contracts for such work. The Contractor shall cooperate fully with other contractors, public officers, and public employees in scheduling and coordinating Contract work. The Contractor shall give other contractors reasonable opportunity to execute their work and shall not interfere with the scheduled work of other contractors, public officers, and public employees.

2. The Department shall not unreasonably interfere with the Contractor's performance of its obligations under this Contract.

VII. SUBCONTRACTS & ASSIGNMENTS

The Contractor shall not assign, sell, transfer, subcontract, or sublet rights or delegate responsibilities under this Contract, in whole or part, without the prior written consent of the Department. The Department agrees that the Contractor may partially subcontract services, provided that the Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of this Contract. When subcontracting, the Contractor agrees to use written subcontracts that conform with federal and state laws. The Contractor shall request Department approval for any assignment at least 20 days prior to its effective date.

VIII. FURTHER WARRANTY

The Contractor warrants that (a) all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with generally recognized standards; and (b) all goods or products furnished pursuant to this Contract shall be free from defects and shall conform to contract requirements. For any item that the Department determines does not conform with the warranty, the Department may arrange to have the item repaired or replaced, either by the Contractor or by a third party at the Department's option, at the Contractor's expense.

IX. INFORMATION OWNERSHIP

Except for confidential medical records held by direct care providers, the Department shall own exclusive title to all information gathered, reports developed, and conclusions reached in performance of this Contract. The Contractor shall not use, except in meeting its obligations under this Contract, information gathered, reports developed, or conclusions reached in performance of this Contract without the express written consent of the Department.

X. SOFTWARE OWNERSHIP

1. If the Contractor develops or pays to have developed computer software exclusively with funds or proceeds from this Contract to perform its obligations under this Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under this Contract, the computer software shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor

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permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

2. If the Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from this Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under this Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

3. If the Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by this Contract, then to the extent allowed by the license agreement between the Contractor and the owner of the software, the Contractor grants to the Department a continuing nonexclusive license for either the Department or a different contractor to use the software in order to perform work substantially identical to the work performed by the Contractor under this Contract. If the Contractor cannot grant the license as required by this section, then the Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under this contract in such a manner to allow the Department or another Contractor to continue the work performed by the contractor under this Contract.

4. The Contractor shall deliver to the Department a copy of the software or information required by this Article within 90 days after the commencement of this Contract and thereafter immediately upon making a modification to any of the software which is the subject of this Contract.

XI. INFORMATION PRACTICES

1. **(Government entities only)** The Contractor shall establish, maintain, and practice information procedures and controls that comply with federal and state law including, as applicable, Utah Code § 25-1-1 *et seq* and the privacy and security standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) & the Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”). The Contractor shall receive or request from the Department per this Contract only information about an individual that is necessary to the Contractor's performance of its duties and functions. Contractor shall use the information only for purposes of the Contract. The Department shall inform the Contractor of any non-public designation of any information it provides to the Contractor. If the Grantee has employees or contractors on-site such individuals will comply with the Department’s confidentiality standards and policies, including, but not limited to, "Appropriate use of state-issued and privately owned information technology

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resources and personal mobile devices #5.01" and "Confidential Access and Confidentiality # 1.11".

2. **(Non-governmental entities only)** The Contractor shall establish, maintain, and practice information procedures and controls that comply with federal and state law including, as applicable, Utah Code § 25-1-1 *et seq* and the privacy and security standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") & the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"). The Contractor shall not release any information regarding any person provided by the Department, unless the Department first consents in writing to the release. If the Grantee has employees or contractors on-site such individuals will comply with the Department's confidentiality standards and policies, including, but not limited to, "Appropriate use of state-issued and privately owned information technology resources and personal mobile devices #5.01" and "Confidential Access and Confidentiality # 1.11".

XII. INDEMNIFICATION

1. **(Governmental entities only)** It is mutually agreed that each party assumes liability for the negligent and wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for this Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.

2. **(Non-governmental entities only)** To the extent authorized by law, the Contractor shall indemnify and hold harmless the Department and any of its agents, officers, and employees, from any claims, demands, suits, actions, proceedings, loss, injury, death, and damages of every kind and description, including any attorney's fees and litigation expenses, which may be brought, made against, or incurred by the Contractor on account of loss or damage to any property, or for injuries to or death of any person, caused by, arising directly or indirectly out of, or contributed to in whole or in part, by reason of any alleged act, omission, professional error, fault, mistake, or negligence of the Contractor or its employees, agents, or representatives, or subcontractors or their employees, agents, or representatives, in connection with, incident to, or arising directly or indirectly out of this Contract, or arising out of workers' compensation claims, unemployment, or claims under similar such laws or obligations. The parties agree that if there are any Limitations of the Contractor's Liability, including a limitation of liability for anyone for whom the Contractor is responsible, such Limitations of Liability will not apply to injuries to persons, including death, or to damages to property.

XIII. SUBMISSION OF REPORTS

If the Contractor is a local health department, it shall submit monthly expenditure reports to the Department in a format approved by the Department. All other contractors shall submit monthly summarized billing statements to the Department. Expenditure reports and billing statements must be submitted to the Department within 30 days following the last day of the month in which the expenditures were incurred or the services provided.

XIV. PAYMENT

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1. If a recipient, a recipient's insurance, or any third-party is responsible to pay for services rendered pursuant to this Contract, the Contractor shall bill and collect for the goods or services provided to the recipient. The Department shall reimburse total actual expenditures, less amounts collected as required by this section.

2. Under no circumstances shall the Department authorize payment to the Contractor that exceeds the amount specified in this Contract without an amendment to the Contract.

3. The Department agrees to make every effort to pay for completed services. Payments are conditioned upon receipt of applicable, accurate, and completed reports prepared by the Contractor and delivered to the Department. The Department may delay or deny payment for final expenditure reports received more than twenty (20) days after the Contractor has satisfied all Contract requirements.

4. By signing this Contract, the Contractor acknowledges that the Department cannot contract for the payment of funds not yet appropriated by the Utah State Legislature or received from federal sources. If funding to the Department is reduced due to an order by the Legislature or the governor, or is required by state law, or if applicable federal funding is not provided to the Department, the Department shall reimburse the Contractor for products delivered and services performed through the date of cancellation or reduction, and the Department shall not be liable for any future commitments, penalties, or liquidated damages.

5. Offeror may quote a prompt payment discount based upon early payment; however, discounts offered for less than 30 days will not be considered in making the award. Contractor shall list Payment Discount Terms on invoices. The prompt payment discount will apply to payments made with purchasing cards and checks. The date from which discount time is calculated will be the date a correct invoice is received or receipt of shipment, whichever is later; except that if testing is performed, the date will be the date of acceptance of the merchandise.

XV. RECORD KEEPING, AUDITS, & INSPECTIONS

1. The Contractor shall use an accrual or a modified accrual basis for reporting annual fiscal data, as required by Generally Accepted Accounting Principles (GAAP). Required monthly or quarterly reports may be reported using a cash basis.

2. The Contractor, and any subcontractors, shall maintain financial and operational records relating to Contract services, requirements, collections, and expenditures in sufficient detail to document all contract fund transactions. The Contractor, and any subcontractors, shall make and maintain all records necessary and reasonable for a full and complete audit, inspection, and monitoring of services by state and federal auditors and Department staff during normal business hours or by appointment, until all audits and reviews initiated by federal and state auditors are completed, or for a period of six (6) years from the date of termination of this Contract, whichever is longer, or for any period required elsewhere in this Contract.

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3. The Contractor shall retain all records which relate to disputes, litigation, and claim settlements arising from Contract performance or cost or expense exceptions initiated by the Director, until all disputes, litigation, claims, or exceptions are resolved.

4. The Contractor shall comply with federal and state regulations concerning cost principles, audit requirements, and Contract administration requirements, cited in Table 1. Unless specifically exempted in this Contract's special provisions, the Contractor must comply with applicable federal cost principles and Contract administration requirements if state funds are received. The Contractor shall also provide the Department with a copy of all reports required by the State of Utah Legal Compliance Audit Guide (SULCAG) as defined in Chapter 2a, Title 51, UCA. All federal and state principles and requirements cited in Table 1 are available on the Web at the addresses indicated. A Contractor who receives federal or state funds may be subject to federal and state reporting requirements. A Contractor who receives \$500,000 or more per year from federal sources may be subject to the federal single audit requirement. Counties, cities, towns, school districts, and all non-profit corporations that receive 50 percent or more of its funds from federal, state or local governmental entities are subject to the State of Utah Legal Compliance Audit Guide. Copies of required reports shall be sent to the Utah Department of Health, Bureau of Financial Audit, Box 144002, Salt Lake City, Utah 84114-4002.

Federal and State Principles and Requirements:

- Cost Principles, Audit, and Administrative Requirements for Federal Awards
- Contractor Principles Requirements
- State or Local Govt. & OMB Circular A-87 OMB Circular A-133SULCAG OMB Common Rule
- Indian Tribal Governments (Circular A-102)
- Hospitals 45 CFR 74 OMB Circular A-133SULCAG OMB Common Rule
- or Circular A-110
- College or University OMB Circular A-21 OMB Circular A-133SULCAG OMB Circular A-110
- Non-Profit Organization OMB Circular A-122 OMB Circular A-133SULCAG OMB Circular A-110
- For-Profit Organization 48 CFR 31 n/a n/a OMB Circular A-110
- Documents Web Address
- OMB Circulars <http://www.whitehouse.gov/omb/circulars/index.html>
- OMB Common Rule <http://www.whitehouse.gov/omb/grants/attach.html>
- CFRs <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>
- SULCAG <http://www.sao.utah.gov/lgResources.html> Select "Legal Compliance Audit Guide"

XVI. CONTRACT ADMINISTRATION REQUIREMENTS:

The Contractor agrees to administer this Contract in compliance with either OMB Common Rule (Circular A-102) or OMB Circular A-110 depending upon the legal status of the Contractor as shown in Table 1. Financial management, procurement, and affirmative step requirements specify that:

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1. The Contractor must have fiscal control and accounting procedures sufficient to: a. permit preparation of reports required by this Contract, and b. permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.
2. The Contractor's financial management systems must meet the following standards:
 - a. *Financial reporting.* Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of this Contract.
 - b. *Accounting records.* The Contractor must maintain records which adequately identify the source and application of funds provided for federally financially-assisted activities. These records must contain information pertaining to the Contract's awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.
 - c. *Internal control.* Effective control and accountability must be maintained for all Contract cash, real and personal property, and other assets. The Contractor must adequately safeguard all such property and must assure that it is used solely for authorized purposes.
 - d. *Budget control.* Actual expenditures or outlays must be compared with budgeted amounts for the Contract. Financial information must be related to performance or productivity data, including the development of unit cost information whenever appropriate or specifically required in this Contract. If unit cost data are required, estimates based on available documentation will be accepted whenever possible.
3. Federal OMB cost principles, federal agency program regulations, and the terms of grant and subgrant, and contract agreements shall be followed in determining the reasonableness, allowability, and allocability of costs.
 - a. *Source documentation.* Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract and subcontract award documents, etc.
 - b. *Cash management.* Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by the Department and the Contractor must be followed whenever advance payment procedures are used.
4. The Contractor shall use its own procurement procedures which reflect applicable state and local laws, rules, and regulations, provided that the procurements conform to applicable federal law and the standards identified in this Contract.
 - a. The Contractor shall maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of its contracts or purchase orders.

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b. The Contractor shall maintain a written code of standards of conduct governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Department or the Contractor shall participate in the selection, award, or administration of a contract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

- i. the employee, officer or agent,
- ii. any member of his immediate family,
- iii. his or her partner; or
- iv. an organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award.

The Department's and the Contractor's officer, employees and agents shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, potential contractors, or parties to subagreements. The Department and the Contractor may set minimum rules where the financial interest is not substantial or the gift is an unsolicited item of nominal intrinsic value. To the extent permitted by state or local law or regulations, such standards or conduct shall provide for penalties, sanctions, or other disciplinary actions for violations of such standards by the Department's or the Contractor's officers, employees, or agents, or by subcontractors or their agents.

c. The Contractor's procedures shall provide for a review of proposed procurements to avoid purchase of unnecessary or duplicative items. Consideration shall be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis shall be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

d. To foster greater economy and efficiency, the Contractor, if a governmental entity, is encouraged to enter into state and local intergovernmental agreements for procurement or use of common goods and services.

e. If allowed by law, the Contractor is encouraged to use federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

f. The Contractor must contract only with responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement.

g. The Contractor shall maintain records sufficient to detail the significant history of a procurement. These records shall include, but are not necessarily limited to the following:

- i. the rationale for the method of procurement,
- ii. selection of contract type,
- iii. contractor selection or rejection, and
- iv. the basis for the contract price.

h. The Contractor may use time and material type contracts only:

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- i. after a determination that no other contract is suitable, and
- ii. if the Contract includes a ceiling price that the Contractor exceeds at its own risk.

i. The Contractor alone shall be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to, source evaluation, protests, disputes, and claims. These standards do not relieve the Contractor of any contractual responsibilities under its contracts.

j. The Contractor shall have protest procedures to handle and resolve disputes relating to its procurements and shall in all instances disclose information regarding the protest to the federal funding agency. A protestor must exhaust all administrative remedies with the Department and the Contractor before pursuing a protest with the federal funding agency.

5. the Contractor shall take all necessary affirmative steps to assure that minority firms, women's business enterprises, and labor surplus area firms are used when possible. Affirmative steps shall include:

- a. Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
- b. Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
- c. Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority business, and women's business enterprises;
- d. Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority business, and women's business enterprises;
- e. Using the services and assistance of the Small Business Administration, and the Minority Business Development Agency of the Department of Commerce; and
- f. Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in Article XVI, section 5, subsections a – e.

XVII. DEFAULT, TERMINATION, & PAYMENT ADJUSTMENT

1. Each party may terminate this Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of this Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within fifteen days of the notice. If the default is not cured within the fifteen days, the party giving notice may terminate this

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Contract 45 days from the date of the initial notice of default or at a later date specified in the notice.

2. The Department may terminate this Contract without cause, in advance of the specified termination date, upon 30 days written notice to the Contractor.

3. The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for this Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate this contract upon 30 days notice to the Contractor.

4. If funding to the Department is reduced due to an order by the Legislature or the governor, or is required by federal or state law, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 days written notice to the Contractor. If the specific funding source for the subject matter of this Contract is reduced, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 written notice to the Contractor.

5. If the Department terminates this Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace the Contractor's obligations. If the termination is due to the Contractor's failure to perform, and the Department procures replacement goods or services, the Contractor agrees to pay the excess costs associated with obtaining the replacement goods or services.

6. If the Contractor terminates this Contract without cause, the Department may treat the Contractor's action as a default under this Contract.

7. The Department may terminate this contract if the Contractor becomes debarred, insolvent, files for bankruptcy or reorganization proceedings, sells 30% or more of the company's assets or corporate stock, or gives notice of its inability to perform its obligations under this contract.

8. If the Contractor defaults in any manner in the performance of any obligation under this Contract, or if audit exceptions are identified, the Department may, at its option, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. Default and audit exceptions for which payment may be adjusted or withheld include disallowed expenditures of federal or state funds as a result of the Contractor's failure to comply with federal regulations or state rules. In addition, the Department may withhold amounts due the Contractor under this Contract, any other current contract between the Department and the Contractor, or any future payments due the Contractor to recover the funds. The Department shall notify the Contractor of the Department's action in adjusting the amount of payment or withholding payment. This Contract is executory until such repayment is made.

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9. The rights and remedies of the Department enumerated in this article are in addition to any other rights or remedies provided in this Contract or available in law or equity.

10. Upon termination of the Contract, all accounts and payments for services rendered to the date of termination shall be processed according to the financial arrangements set forth herein for approved services rendered to date of termination. If the Department terminates this Contract, the Contractor shall stop all work as specified in the notice of termination. The Department shall not be liable for work or services performed beyond the termination date as specified in the notice of termination.

11. Any of the following events may constitute cause for the Department to declare Contractor in default of the Contract: a. Nonperformance of contractual requirements; b. A material breach of any term or condition of this Contract. The Department shall issue a written notice of default providing a ten (10) day period in which Contractor shall have an opportunity to cure. Time allowed for cure shall not diminish or eliminate Contractor's liability for damages. If the default remains after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: c. Exercise any remedy provided by law; d. Terminate this Contract and any related agreements or portions thereof; e. Impose liquidated damages, if liquidated damages are listed in the contract; f. Suspend Contractor from receiving future solicitations.

12. In the event of such termination, the Contractor shall be compensated for services properly performed under this Contract up to the effective date of the notice of termination. The Contractor agrees that in the event of such termination for cause or without cause, Contractor's sole remedy and monetary recovery from the State is limited to full payment for all work properly performed as authorized under this Contract up to the date of termination as well as any reasonable monies owed as a result of the Contractor having to terminate contracts necessarily and appropriately entered into by the Contractor pursuant to this Contract. Contractor further acknowledges that in the event of such termination, all work product, which includes but is not limited to all manuals, forms, contracts, schedules, reports, and any and all documents produced by Contractor under this Contract up to the date of termination are the property of the State and shall be promptly delivered to the State.

XVIII. FEDERAL REQUIREMENTS

The Contractor shall comply with all applicable federal requirements. To the extent that the Department is able, the Department shall give further clarification of federal requirements upon the Contractor's request. If the Contractor is receiving federal funds under this Contract, certain federal requirements apply. The Contractor agrees to comply with the federal requirements to the extent that they are applicable to the subject matter of this Contract and are required by the amount of federal funds involved in this Contract.

1. Civil Rights Requirements:

- a. The Civil Rights Act of 1964, Title VI, provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity

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receiving federal financial assistance. The Health and Human Services regulation implementing this requirement is 45 CFR Part 80.

b. The Civil Rights Act of 1964, Title VII, (P.L. 88-352 & 42 U.S.C. § 2000e et seq.) prohibits employers from discriminating against employees on the basis of race, color, religion, national origin, and sex. Title VII applies to employers of fifteen or more employees, and prohibits all discriminatory employment practices.

c. The Rehabilitation Act of 1973, as amended, section 504, provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation 45 CFR Part 84 implements this requirement.

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), prohibits unreasonable discrimination on the basis of age in any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing the provisions of the Age Discrimination Act is 45 CFR Part 91.

e. The Education Amendments of 1972, Title IX, (20 U.S.C. §§ 1681-1683 and 1685-1686), section 901, provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving federal financial assistance. Health and Human Services regulation 45 CFR Part 86 implements this requirement.

f. Executive Order No. 11246, as amended by Executive Order 11375, relates to "Equal Employment Opportunity" (for all construction contracts and subcontracts in excess of \$10,000), and prohibits discrimination in employment decisions on the basis of race, color, religion, sex, or national origin. It also requires covered contractors to take affirmative action to ensure equal opportunity is provided in all aspects of their employment.

g. Americans with Disabilities Act of 1990, (P.L.101-336), section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), prohibits discrimination on the basis of disability.

h. The Public Health Service Act, as amended, Title VII, section 704 and Title VIII, section 855, forbids the extension of federal support for health manpower and nurse training programs authorized under those titles to any entity that discriminates on the basis of sex in the admission of individuals to its training programs. Health and Human Services regulation implementing this requirement is 45 CFR Part 83.

i. The Public Health Service Act, as amended, section 526, provides that drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment because of their drug abuse or drug dependence, by any private or public general

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hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefiting from federal financial assistance by 45 CFR Part 84.

j. The Public Health Service Act, as amended, section 522, provides that alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefiting from federal financial assistance by 45 CFR Part 84.

2. Confidentiality: The Public Health Service Act, as amended, sections 301(d) and 543, requires that certain records be kept confidential except under certain specified circumstances and for specified purposes. Confidential records include records of the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with the performance of any activity or program relating to drug abuse prevention, i.e., drug abuse education, training, treatment, or research, or alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research that is directly or indirectly assisted by the federal government. Public Health Service regulations, 42 CFR Parts 2 and 2a, implement these requirements.

3. Lobbying Restrictions: Lobbying restrictions per 31 U.S.C. § 1352, require the Contractor to abide by this section and to place the section's language in all of the Contractor's contracts:

a. No federal funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any federal 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 of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Federal Standard Form LLL, "Disclosure Form to report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this article be included in the award documents for all subcontracts and that subcontractors shall certify and disclose accordingly.

4. Debarment, suspension or other ineligibility: The Contractor certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in this Contract by any governmental department or agency. The Contractor must notify the Department within thirty (30) days in accordance with the notification

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requirements specified in Article III, section 11 of this Contract if the Contractor has been debarred or excluded by any governmental entity within the contract period. Debarment regulations are stated in Health and Human Services regulation 45 CFR Part 76.

5. Environmental Impact: The National Environmental Policy Act of 1969 (NEPA) (Public Law 91-190) establishes national policy goals and procedures to protect and enhance the environment. NEPA applies to all federal agencies and requires them to consider the probable environmental consequences of any major federal activity, including activities of other organizations operating with the concurrence or support of a federal agency. This includes grant-supported activities under this Contract if federal funds are involved. Additional environmental requirements include:

- a. The institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order 11514;
- b. The notification of violating facilities pursuant to Executive Order 11738 (all contracts, subcontracts, and subgrants in excess of \$100,000);
- c. The protection of wetlands pursuant to Executive Order 11990;
- d. The evaluation of flood hazards in floodplains in accordance with Executive Order 11988;
- e. The assurance of project consistency with the approved state management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.);
- f. The conformity of federal actions to State (Clean Air) Implementation Plans under Section 176 (c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§ 7401 et seq.);
- g. The protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523),
- h. The protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205) and;
- i. The protection of the national wild and scenic rivers system under the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 *et seq.*).

6. Human Subjects: The Public Health Service Act, section 474(a), implemented by 45 CFR Part 46, requires basic protection for human subjects involved in Public Health Service grant supported research activities. Human subject is defined in the regulation as "a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual or identifiable private information." The regulation extends to the use of human organs, tissues, and body fluids from individually identifiable human subjects as well as to graphic, written, or recorded information derived from individually identifiable human subjects. The regulation also specifies additional protection for

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certain classes of human research involving fetuses, pregnant women, human in vitro fertilization, and prisoners. However, the regulation exempts certain categories of research involving human subjects which normally involve little or no risk. The exemptions are listed in 45 CFR Part 46.101(b). The protection of human subjects involved in research, development, and related activities is found in P.L. 93-348.

7. Sterilization: Health and Human Services and Public Health Service have established certain limitations on the performance of nonemergency sterilizations by Public Health Service grant-supported programs or projects that are otherwise authorized to perform such sterilizations. Public Health Service has issued regulations that establish safeguards to ensure that such sterilizations are performed on the basis of informed consent and that the solicitation of consent is not based on the withholding of benefits. These regulations, published at 42 CFR Part 50, Subpart B, apply to the performance of nonemergency sterilizations on persons legally capable of consenting to the sterilization. Federal financial participation is not available for any sterilization procedure performed on an individual who is under the age of 21, legally incapable of consenting to the sterilization, declared mentally incompetent, or is institutionalized.

8. Abortions and Related Medical Services: Federal financial participation is generally not available for the performance of an abortion in a grant-supported health services project. For further information on this subject, consult the regulation at 42 CFR Part 50, Subpart C.

9. Recombinant DNA and Institutional Biosafety Committees: Each institution where research involving recombinant DNA technology is being or will be conducted must establish a standing Biosafety Committee. Requirements for the composition of such a committee are given in Section IV of *Guidelines for Research Involving Recombinant DNA Molecules*, (49 FR 46266 or latest revision), which also discusses the roles and responsibilities of principal investigators and contractor institutions. *Guidelines for Research Involving Recombinant DNA Molecules and Administrative Practices Supplement* should be consulted for complete requirements for the conduct of projects involving recombinant DNA technology.

10. Animal Welfare: The *Public Health Service Policy on Humane Care and Use of Laboratory Animals By Awardee Institutions* requires that applicant organizations establish and maintain appropriate policies and procedures to ensure the humane care and use of live vertebrate animals involved in research activities supported by Public Health Service. This policy implements and supplements the U.S. *Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research, and Training* and requires that institutions use the *Guide for the Care and Use of Laboratory Animals* as a basis for developing and implementing an institutional animal care and use program. This policy does not affect applicable state or local laws or regulations which impose more stringent standards for the care and use of laboratory animals. All institutions are required to comply, as applicable, with the Animal Welfare Act as amended (7 U.S.C. 2131 et seq.) and other federal statutes and regulations relating to animals. These documents are available from the Office for Protection from Research Risks (OPRR), National Institutes of Health, Bethesda, MD 20892, (301) 496-7005.

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11. Contract Provisions: The Contractor must include the following provisions in its contracts, as limited by the statements enclosed within the parentheses following each provision:
- a. Administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provides for such sanctions and penalties as may be appropriate. (Contracts other than small purchases. Small purchases involve relatively simple and informal procurement methods that do not cost more than \$100,000 in aggregate.)
 - b. Termination for cause and for convenience by the contractor or subgrantee including the manner by which it will be effected and the basis for settlement. (All contracts in excess of \$10,000)
 - c. Compliance with Executive Order 11246 of September 24, 1965 entitled "Equal Employment Opportunity," as amended by Executive Order 11375 of October 13, 1967 and as supplemented in Department of Labor regulations (41 CFR Chapter 60). (All construction contracts awarded in excess of \$10,000 by the Contractor and its contractors or subgrantees)
 - d. Compliance with the Copeland "Anti-Kickback" Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR Part 3). (All contracts and subgrants for construction or repair)
 - e. Compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (29 CFR Part 5), which sets requirements concerning minimum wages. (Construction contracts in excess of \$2,000 awarded when required by federal grant program legislation)
 - f. Compliance with the Contract Work Hours and Safety Standards Act, sections 103 and 107, (40 U.S.C. 3701 et seq.) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts awarded in excess of \$2,000, and in excess of \$2,500 for other contracts which involve the employment of mechanics or laborers)
 - g. Notice of the federal awarding agency requirements and regulations pertaining to reporting.
 - h. Notice of federal awarding agency requirements and regulations pertaining to patent rights with respect to any discovery or invention which arises or is developed in the course of or under such contract.
 - i. Federal awarding agency requirements and regulations pertaining to copyrights and rights in data.
 - j. Access by the Department, the Contractor, the Federal funding agency, the Comptroller General of the United States, or any of their duly authorized representatives to any books,

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documents, papers, and records of the Contractor which are directly pertinent to that specific contract for the purpose of making audit, examination, excerpts, and transcriptions.

k. Compliance with all applicable standards, orders, or requirements of the Clean Air Act, section 306 (42 U.S.C. 7606), the Clean Water Act, section 508, the Clean Water Act, section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Chapter 1 et seq.). (Contracts, subcontracts, and subgrants of amounts in excess of \$100,000).

l. Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163).

12. (Governmental entities only) Merit System Standards: The Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763), requires adherence to prescribed standards for merit systems funded with federal funds.

13. Misconduct in Science: The United States Public Health Service requires certain levels of ethical standards for all PHS grant-supported projects and requires recipient institutions to inquire into, investigate and resolve all instances of alleged or apparent misconduct in science. Issues involving potential criminal violations must be promptly reported to the HHS Office of Inspector General. (See regulations in 42 CFR Part 93.)

XIX. STATE REVIEWS AND LIMITATIONS: The Department has the right to perform plan checks, plan reviews, other reviews, comment upon Contractor's services, and approve Contractor's services. This right does not relieve Contractor from its professional and legal responsibilities for services per the contract. No review, approval, acceptance, or payment by the Department or any entity or user for any services per the contract shall operate as a waiver by the Department of any of its rights per this contract or of any cause of action arising out of the performance or nonperformance of the contract; Contractor may be liable to the Department per applicable laws for all damages to the Department for wrongful acts, error, or omissions of Contractor or its subcontractor or subconsultants at any tier (if any).

XX. PERFORMANCE EVALUATION: The Department may conduct a performance evaluation of Contractor's services, including services performed by specific personnel of Contractor. The Department may make available to Contractor the results of all evaluations.

Attachment B – Special Provisions

Article 1: Introductory Provisions

1.1 Parties

(A) This Contract is between the State of Utah, acting by and through its Department of Health hereinafter referred to as “Department”, and Central Utah Counseling Center, hereinafter referred to as “Contractor”. Together, the Department and Contractor shall be referred to as the “Parties”.

(B) In compliance with 42 CFR 438.602(i), the Contractor agrees that during the duration of this Contract, the Contractor shall not be located outside of the United States, and that no claims paid by the Contractor to a network provider, out-of-network provider, Subcontractor, or financial institution located outside of the United States are considered in the development of actuarially sound capitation rates.

1.2 Notices

Any notices that are not otherwise specified in the Contract but are permitted or required under this Contract, shall be in writing and shall be transmitted by:

- (a) certified or registered United States mail, return receipt requested;
- (b) personal delivery; or
- (c) expedited delivery.

Such notices shall be addressed as follows:

Department (if by mail):

Utah Department of Health
Division of Medicaid and Health Financing
Director, Bureau of Managed Health Care
P.O. Box 143108
Salt Lake City, UT 84114

Department (if in person):

Utah Department of Health
Division of Medicaid and Health Financing
Director, Bureau of Managed Health Care
288 North 460 West
Salt Lake City, UT 84114

Contractor:

Central Utah Counseling Center
152 North 400 West
Ephraim, UT 84627

In the event that the above contact information changes, the Party changing the contact information shall notify the other Party in writing of such change.

1.3 Service Area

1.3.1 Service Area, Generally

(A) The Service Area is the specific geographic area within which the Medicaid Eligible Individual must reside to enroll in the Contractor's PMHP. The Service Area for this Contract is Juab, Millard, Piute, Sanpete, Sevier and Wayne counties.

(B) The Contractor shall provide adequate assurances and supporting documentation that the Contractor has the capacity to serve the expected enrollment in the Service Area.

1.3.2 Residency in Service Area

The Department has sole discretion to determine whether an Enrollee resides in a particular Service Area.

1.3.3 Mandatory/Voluntary Enrollment Service Areas

Medicaid Enrollees with reported county code(s) in the Service Area are mandatorily enrolled in the Contractor's PMHP.

Article 2: Definitions

2.1 Contract Definitions

For purposes of this Contract the following definitions apply, unless otherwise specified:

Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and results in unnecessary cost to the Medicaid program, or in reimbursement of services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care. It also includes Medicaid member practices that result in unnecessary cost to the Medicaid program.

Accountable Care Organization (ACO) means a Utah Managed Care Organization (MCO) that contracts with the Department to provide medical services to Medicaid members.

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this Contract, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of Capitation Rates.

Adult Expansion Population means the eligible membership limited to parents and adults without dependent children, earning up to 133% of the federal poverty level.

Advance Directive means a written instruction such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination means:

1. the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of Covered Service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service, but not if the denial, in whole or in part, of a payment for a service is solely because the claim does not meet the definition of a Clean Claim;
4. the failure to provide services in a timely manner, defined as failure to meet performance standards for appointment waiting times specified in Article 10.4 of this Contract;
5. the failure of the Contractor to act within the timeframes established for resolution and notification of Grievances and Appeals;

6. for a resident of a rural area with only one MCO, the denial of an Enrollee's right to exercise the Enrollee's right to obtain services outside the network; or
7. the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Aggrieved Person means an Aggrieved Person as defined by Utah Administrative Code R410-14-2 or an Enrollee's legal guardian or other authorized representative.

Appeal means a review of an Adverse Benefit Determination made by the Contractor.

Capitation means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Contractor for the performance of all of the Contractor's duties and obligations pursuant to this Contract.

Capitation Payment means the payment the Department makes to the Contractor on behalf of each Enrollee, and is based on the actuarially sound capitation rate for the provision of services under the State plan. The Department makes the payment regardless of whether the particular Enrollee receives services during the period covered by the payment.

Capitation Rate means the rate negotiated between the Contractor and Department for each Medicaid eligibility group or Capitation Rate Cell. In developing actuarially sound Capitation Rates, the Department will apply the elements required in 42 CFR 438.6(c).

Centers for Medicare and Medicaid Services (CMS) means the federal agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs, and works with states to administer the Medicaid program.

Claim includes (1) a bill for services, (2) a line item of services, or (3) all services for one Enrollee within a bill.

Clean Claim means a Claim that can be processed without obtaining any additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating from the Contractor's claims system. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse or a Claim under review for medical necessity.

Cold-Call Marketing means any unsolicited personal contact by the Contractor, its employees, Network Providers, agents, or Subcontractors with a Potential Enrollee for the purposes of Marketing.

Comprehensive Risk Contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: (1) outpatient hospital services; (2) rural health clinic services; (3) FQHC services; (4) other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) EPSDT services; (7) family planning services (8) physician services; (9) home health services.

Confidential Data means any non-public information maintained in an electronic format used or exchanged by the Parties in the course of the performance of this contract whose collection, disclosure, protection, and disposition is governed by state or federal law or regulation, particularly information subject to the Gramm-Leach-Bliley Act, the Health Insurance Portability and Accountability Act, and other equivalent state and federal laws. Confidential Data includes, but is not limited to, social security numbers, birth dates, medical records, Medicaid identification numbers, medical Claims and Encounter Data.

Convicted means a judgment of conviction entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

Covered Services means services identified in Attachments B and C of this Contract that the Contractor is required to provide and pay for pursuant to the terms of this Contract.

Disclosing Entity means a Medicaid Provider (other than an individual practitioner or group of practitioners), or a Fiscal Agent. For purposes of the Contract, Disclosing Entity means the Contractor.

Division of Occupational and Professional Licensing (DOPL) means an agency within the Utah Department of Commerce which administers and enforces specific laws related to the licensing and regulation of certain occupations and professions.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program means the federally mandated program, described in 42 CFR Part 441, Subpart B, that provides comprehensive and preventive health care services for children.

Electronic Resource Eligibility Product (eREP) means the computer support system used by eligibility workers to determine Medicaid eligibility and store eligibility information.

Eligibility Transmission means the 834 Benefit Enrollment and Maintenance File.

Emergency Medical Condition means 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:

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

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter means an individual service or procedure provided to an Enrollee that would result in a Claim.

Encounter Data means the information relating to the receipt of any item(s) or service(s) by an Enrollee that is subject to the requirements of 42 CFR 438.242 and 42 CFR 438.818.

Enrollee means any Medicaid Eligible Individual whose name appears on the Department's eligibility transmission as enrolled in the Contractor's PMHP.

Enrollees with Special Health Care Needs means Enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

Exclusion or Excluded means that the items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

External Quality Review (EQR) means the analysis and evaluation of information by an EQRO of aggregated information on quality, timeliness, and access to the health care services that an MCE, or its Network Providers, furnish to its Enrollees.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Federal Acquisition Regulation means the regulation found at Title 48 of the Code of Federal Regulations, Chapter 1, Parts 1 through 53.

Federal Financial Participation (FFP) means, in accordance with 42 CFR 400.203, the federal government's share of a state's expenditures under the Medicaid program.

Federal Health Care Program means (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code) of the Social Security Act; or (2) any State Health Care Program, as defined in Section 1128(h) of the Social Security Act.

Federally Qualified Health Center (FQHC) means a community-based organization that qualifies for funding under Section 330 of the Public Health Service Act (PHS), and that provides comprehensive primary care and preventive care, including health and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Federally Qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Services Act.

Fee-for-Service (FFS) means the Medicaid service delivery system under which services are billed directly to and paid directly by Medicaid based on an established fee schedule.

Fiscal Agent means a contractor that processes or pays vendor Claims on behalf of the Medicaid agency or Contractor.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person including any act that constitutes fraud under applicable federal or state law.

Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee, failure to respect the Enrollee's rights regardless of whether remedial action is requested.

Grievance and Appeal System means the processes the Contractor implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them.

Health Insuring Organization (HIO) means a county operated entity, that in exchange for Capitation Payments, covers services for beneficiaries (1) through payments to, or arrangements with, providers; (2) under a Comprehensive Risk Contract with the State; and (3) meets the following criteria: (i) first became operational prior to January 1, 1986; or (ii) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Healthcare Effectiveness Data and Information Set (HEDIS) means a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information for reliable comparison of health plan performance developed and maintained by NCQA.

Healthy Outcomes Medical Excellence (HOME) means a Managed Care Organization under contract with the Department to provide medical and mental health services for the eligible Medicaid enrollees who have a co-occurring mental health and developmental disability.

Home and Community-Based Waiver Services means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver of statutory requirements granted under the provisions of 42 CFR Part 441, Subpart G. Home and Community-Based Waiver Services cover an array of services that are cost-effective and necessary for an individual to avoid institutionalization.

Indian means an individual, as defined by 25 U.S.C. 1603(c), 1603(f), or 1679(b) or who has been determined eligible, as in Indian, pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers.

Indian Health Care Provider means a health care program, operated by Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC 1603).

Indirect Ownership Interest means an Ownership Interest in an entity that has an Ownership Interest in the Contractor. This term includes an Ownership Interest in any entity that has an Indirect Ownership Interest in the Contractor.

Institutions for Mental Diseases (IMD) means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an institution for mental diseases.

K Children means Enrollees identified in the Eligibility Transmission as being in Rate Cell K.

Legacy Medicaid Population means the eligible membership groups of children 0-18, K Children, pregnant women, blind and disabled, aged, members eligible under the cancer program, and adults on Family Medicaid programs.

List of Excluded Individuals/Entities (LEIE) means the Federal Department of Health and Human Services-Office of Inspector General's (HHS-OIG's) database regarding individuals and entities currently Excluded by the HHS-OIG from participation in Medicare, Medicaid, and all other Federal Health Care Programs. Individuals and entities who have been reinstated are removed from the LEIE. The LEIE website is located at <http://www.exclusions.oig.hhs.gov>.

Local Mental Health/Substance Abuse Authority means the county authority responsible to provide directly or by subcontract mental health and substance use disorder services to residents of the authority's county or counties in accordance with Utah Code Ann. 17-43-301 and 17-43-201.

Long-term Services and Supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Entity (MCE) means MCOs, PIHPs, PAHPs, PCCMs, and HIOs.

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a Comprehensive Risk Contract, and that is – (1) A federally qualified HMO that meets the Advance Directives requirements of 42 CFR 489, Subpart I; or (2) Any public or private entity that meets the Advance Directives requirement of 42 CFR 489, Subpart I and is determined by the Secretary of the U.S. Department of Health and Human Services to also meet the following conditions: (i) Makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other

Medicaid members within the area served by the entity and (ii) meets the solvency standards of 42 CFR 438.116.

Managed Care Program means a managed care delivery system operated by the State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor.

Marketing means any communication from Contractor, its employees, Network Providers, agents or Subcontractors to a Potential Enrollee that can reasonably be interpreted to influence the Potential Enrollee to enroll in Contractor's Medicaid product, or either to not enroll in, or to disenroll from another PMHP's Medicaid product.

Marketing Materials means materials that are produced in any medium, by or on behalf of the Contractor, its employees, affiliated Providers, agents or Subcontractors to a Potential Enrollee that can reasonably be intended to market to Potential Enrollees.

Medicaid means the medical assistance program authorized under Title XIX of the Social Security Act.

Medicaid Eligible Individual means any individual who has been deemed eligible for Medicaid benefits by the Utah Department of Human Services or the Utah Department of Workforce Services.

Medicaid Fraud Control Unit (MFCU) means the statutorily authorized criminal investigation unit in the Utah Attorney General's Office charged with investigating and prosecuting Medicaid Fraud.

Medicaid Information Bulletin (MIB) means the official, periodic publication of the Division of Medicaid and Health Financing to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Medical Loss Ratio (MLR) means a measure of the percentage of premium dollars that a health plans spends on medical claims and quality improvements, versus administrative costs. MLR is described in Article 12.5.

Medically Necessary or Medical Necessity means needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member Services means a method of assisting Enrollees in understanding Contractor policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.

National Committee for Quality Assurance (NCQA) means a private, non-profit organization dedicated to improving health care quality by evaluating and reporting on the

quality of managed care and other health care organizations in the United States. NCQA developed HEDIS and maintains and updates a database of HEDIS results.

Network Provider means any provider, group of providers, or entity that has a Network Provider agreement with the Contractor or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of the Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement.

Non-Network Provider means an any individual, corporate entity, or any other organization that is engaged in the delivery of health care services, is legally authorized to do so by the State in which it delivers the services and who does not have a contract or any other pre-arranged payment or employment agreement with the Contractor.

Non-Traditional Enrollee means an Enrollee who qualifies for the reduced benefit plan provided in the 1115 Demonstration Waiver.

Notice of Adverse Benefit Determination means written notification to an Enrollee and written or verbal notification to a Provider when applicable, of an Adverse Benefit Determination that will be taken by the Contractor.

Notice of Appeal Resolution means written notification to an Enrollee, and a Provider when applicable, of the Contractor's resolution of an Appeal.

Office of Recovery Services (ORS) means an agency within the Utah Department of Human Services.

Other Disclosing Entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes:

1. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare;
2. Any Medicare intermediary or carrier: and
3. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Social Security Act.

Overpayment means any payment made to a Network Provider by a Managed Care Program to which the Network Provider is not entitled to under Title XIX of the Social Security Act or any payment to a Managed Care Program by the Department to which the Managed Care Program is not entitled to under Title XIX of the Social Security Act.

Overpayment Discovery Date means the date the Contractor issues to a Provider a formal notice of recovery of an alleged Overpayment related to Fraud, Waste, or Abuse.

Ownership Interest means the possession of equity in the capital, the stock, or the profits of the Contractor.

Performance Improvement Project (PIP) means a project designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on the health outcomes and Enrollee satisfaction.

Person with an Ownership or Control Interest means a person or corporation that:

1. Has an Ownership Interest totaling 5 percent or more in the Contractor;
2. Has an Indirect Ownership Interest equal to 5 percent or more in the Contractor;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in the Contractor;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the property or assets of the Contractor;
5. Is an officer or director of a Disclosing Entity that is organized as a corporation; or
6. Is a partner in the Contractor that is organized as a partnership.

Physician Incentive Plan means any compensation arrangement between the Contractor and a physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Enrollees.

Post-stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the Enrollee's condition.

Potential Enrollee means a Medicaid member who is subject to mandatory enrollment or may voluntarily elect to enroll in a given Managed Care Program, but is not yet an Enrollee of a specific MCE.

Prepaid Ambulatory Health Plan (PAHP) means an entity that provides medical services to Enrollees under contract with the Department and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State Plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and does not have a Comprehensive Risk Contract.

Prepaid Inpatient Health Plan (PIHP) means an entity that provides medical services to Enrollees under contract with the Department, and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State Plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of inpatient hospital or

institutional services for its Enrollees; and does not have a Comprehensive Risk Contract. The Contractor is a PIHP.

Prepaid Mental Health Plan (PMHP) means the Medicaid mental health and substance use disorder managed care plan that covers inpatient and outpatient mental health services and outpatient substance use disorder services.

Primary Care Case Management (PCCM) means a system under which a PCCM contracts with the Department to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid members.

Provider means a Network Provider or a Non-Network Provider.

Quality Assessment and Performance Improvement Program (QAPI Program or QAPIP) means the Contractor's plan to establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its Enrollees in accordance with 42 CFR 438.330.

Rate Cell means a set of mutually exclusive categories of Enrollees that is defined by one or more characteristics for the purpose of determining the Capitation Rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Enrollee is categorized in one of the Rate Cells for each unique set of mutually exclusive benefits under the Contract.

Rating Period means a period of 12 months selected by the Department for which the actuarially sound Capitation Rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a).

Readily Accessible means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Recovery Period means the period of time the Contractor is allowed to recover any Overpayments on adjudicated claims related to Fraud, Waste, or Abuse, ending 12 months from the Overpayment Discovery Date, or longer if the Contractor is actively collecting the Overpayment from the Provider.

Restriction Program means the program required by 42 CFR 431.54(e) and 42 CFR 456.3 that provides safeguards against inappropriate and excessive use of Medicaid services.

Risk Contract means a contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk Corridor means a risk sharing mechanism in which the Department and the Contractor may share in profits and losses under the Contract outside of a predetermined threshold amount.

Service Area means the counties enumerated in Article 1.3 of this Contract.

Service Authorization Request means a Provider's or Enrollee's request to the Contractor for the provision of a service.

State means the single state agency as specified in 42 CFR 431.10.

State Fair Hearing means the process set forth in subpart E of part 431 of CFR Title 42.

State Fiscal Year (SFY) means twelve calendar months commencing on July 1 and ending on June 30 following or the 12-month period for which the State budgets funds.

State Health Care Program means:

1. a State plan approved under Title XIX of the Social Security Act;
2. any program receiving funds under Title V of the Social Security Act or from an allotment to a state under such title;
3. any program receiving funds under Title XX of the Social Security Act or from an allotment to a state under such title; or
4. a state child health plan approved under Title XXI of the Social Security Act.

State Match means the current percentage of the State's share of Medicaid expenditures as defined under 42 CFR 433.10.

State Plan means the Utah State Plan for organization and operation of the Medicaid program as defined pursuant to Section 1902 of the Social Security Act (42 U.S.C. 1396a).

Subcontract means any written agreement between the Contractor and another party to fulfill the requirements of this Contract.

Subcontractor means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the Department. A Network Provider is not a Subcontractor by virtue of the Network Provider's agreement with the Contractor. This definition of Subcontractor applies to Attachment B, C, and D unless otherwise specified.

Suspended means Providers who have been Convicted of a program-related offense in a federal, state, or local court, and therefore, their items and services will not be reimbursed under Medicaid.

System for Award Management (SAM) means the official U.S. Government system, accessible to all, that consolidates Central Contractor Administration and Excluded Parties List System and other contractor databases. The purpose of SAM is to provide a single comprehensive list of individuals and firms excluded by federal government agencies from receiving federal contracts or federal-approved subcontracts and from certain types of federal financial and non-financial assistance and benefits.

Teletypewriter/Telecommunication Device (TTY/TDD) means any type of text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

Third Party means, but is not limited to, an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, and governmental programs, that may be obligated to pay all or part of the expenditures for Covered Services.

Third Party Liability (TPL) means a Third Party's obligation to pay all or part of the expenditures for Covered Services furnished under this Contract.

Traditional Enrollee means an Enrollee who is eligible for the scope of services contained in the State Plan provided to Medicaid Eligible Individuals as identified in the State Plan.

Utah Medicaid Integrated Care Plan (UMIC Plan) means a managed care plan responsible to provide both physical health and behavioral health (i.e., mental health and substance use disorder) services.

Waste means overutilization of resources or inappropriate payment.

Article 3: Marketing and Enrollment

3.1 Marketing Activities

3.1.1 Marketing, Generally

(A) The Contractor, its employees, Network Providers, agents, or Subcontractors shall not conduct direct or indirect Marketing of the PMHP.

(B) The Contractor shall not market to or otherwise attempt to influence the Department's Health Plan Representatives or local Health Department staff to encourage Enrollees or Potential Enrollees to enroll in the Contractor's PMHP.

3.1.2 Prohibited Marketing Activities

The Contractor, its employees, Network Providers, agents, or Subcontractors are prohibited from:

- (1) directly or indirectly, conducting door-to-door, telephonic, or other Cold-Call Marketing activities;
- (2) influencing a Potential Enrollee's enrollment in conjunction with the sale or offering of any private insurance; and
- (3) distributing any materials that include statements that will be considered inaccurate, false, or misleading. Such statements can include that the Potential Enrollee must enroll with the

Contractor in order to obtain or not to lose benefits; or that the Contractor has been endorsed by CMS, the federal or state government, or similar entity.

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

The Contractor shall maintain policies and procedures related to Marketing that ensure compliance with the requirements described in Article 3.

3.2.2 Department Approval

All Marketing Materials must be reviewed and have the approval of the Department prior to distribution. The Contractor understands and agrees that when submitting any Marketing Materials to the Department for review, the Department is required to consult with the Medical Care Advisory Committee established under 42 CFR 431.12 or an advisory committee with similar membership.

3.2.3 Specify Methods

The Contractor shall specify the methods by which it assures the Department that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud Potential Enrollees or the Department.

3.2.4 Distribution of Marketing Materials

The Contractor shall distribute Marketing Materials in the entire Service Area the Contractor serves.

3.2.5 Marketing Activities Prohibited

The Department has determined that no Marketing activities specifically directed at Potential Enrollees will be allowed under this Contract.

3.3 Enrollment Process

3.3.1 Enrollment by the Department

The Department shall determine which Medicaid Eligible Individuals are to be enrolled in the Contractor's PMHP.

3.3.2 Period of Enrollment

(A) An Enrollee shall be considered enrolled in the Contractor's PMHP during the months in which the Contractor receives a Capitation Payment from the Department.

(B) Until the Department notifies the Contractor that an Enrollee is no longer enrolled with the Contractor, the Contractor shall assume that the Enrollee continues to be enrolled. The Contractor is responsible for verifying enrollment using the most current information available from the Department.

(C) The Contractor shall be responsible for payment of all Clean Claims for Covered Services rendered to an Enrollee for whom the Contractor has received a Capitation Payment. The Contractor is responsible for payment even where an Enrollee changes their county of residence during the month that the Contractor received a Capitation Payment.

3.3.3 Retroactive Enrollment

The time period of retroactive eligibility may exceed 12 months; however, the Department shall pay up to 12 months of Capitation Payments to the Contractor and the Contractor shall be responsible for providing Covered Services during those 12 months.

3.3.4 Prohibition Against Conditions on Enrollment

(A) The Contractor shall accept eligible Enrollees in the order in which they apply without restrictions unless such restriction is authorized by the Department, up to the limits set under the Contract.

(B) The Contractor shall not discriminate against Enrollees or Potential Enrollees on the basis of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.

(C) The Contractor shall not discriminate against Enrollees or Potential Enrollees on the basis of health status or the need for health services.

3.3.5 Enrollment Process

The Department may, at any time, revise the enrollment procedures. The Department will advise the Contractor of the anticipated changes in advance whenever possible. The Contractor shall have the opportunity to make comments and provide input on the changes. The Contractor will be bound by the changes in enrollment procedures.

3.4 Eligibility Transmission

3.4.1 General Requirements

(A) The Department shall provide to the Contractor an Eligibility Transmission which is an electronic file that includes data on individuals the Department certifies as being Medicaid-eligible and who have been enrolled with the Contractor.

(B) The Eligibility Transmission will include new Enrollees, reinstated Enrollees, retroactive Enrollees, terminated Enrollees and Enrollees whose eligibility information results in a change to a critical field.

(C) The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard.

(D) The Contractor shall have the ability to receive and process Eligibility Transmissions.

(E) Critical fields found in the Eligibility Transmission include: Enrollee's case number, case name, eREP identification number, name, date of birth, date of death, social security number, gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, (including those for Indians) eligibility start date, Third Party coverage, county, address, phone number, and if applicable, the Enrollee's Provider under the Restriction Program when such information is available.

(F) The appearance of an individual's name on the Eligibility Transmission, other than a deleted Enrollee, shall be evidence to the Contractor that the Department has determined that the individual is enrolled in the PMHP and qualifies for Medical Assistance under Tile XIX of the Social Security Act.

3.4.2 Eligibility Transmission, Specific Types of Enrollees

(A) New Enrollees shall be enrolled in the PMHP until they have been terminated from the PMHP. New Enrollees will not appear on future Eligibility Transmissions unless there is a change in a critical field.

(B) Reinstated Enrollees are individuals who were enrolled for the previous month and also terminated at the end of the previous month. These Enrollees are eligible retroactively to the beginning of the current month.

(C) Terminated Enrollees are individuals who are no longer eligible for Medicaid, were disenrolled from the PMHP, or had their Capitation Payment retracted.

3.4.3 Eligibility File, Contractor Responsibilities

(A) The Contractor shall be responsible for ensuring that it is using the most recent Eligibility Transmission to determine eligibility and when processing claims.

(B) The Contractor shall follow the policies and procedures found in the Department's *834 Companion Guide*, and the *ASC X12 Benefit Enrollment and Maintenance (834) Implementation Guide*.

3.5 Enrollee Information

3.5.1 General Requirements

(A) The Contractor shall write all Enrollee informational, instructional, and educational materials, in a manner that may be easily understood, and to the extent possible, at a sixth grade reading level.

(B) The Enrollee information required under Article 3.5 may not be provided electronically unless:

(1) it is in a format that is Readily Accessible;

(2) the information is placed on a location in the Contractor's website that is prominent and Readily Accessible;

(3) the information is in an electronic form which can be electronically retained and printed;

(4) the information is consistent with content and language requirements; and

(5) the Contractor informs the Enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.

(C) The Contractor shall have mechanisms in place to help Enrollees and Potential Enrollees understand the requirements and benefits of their plan.

(D) The Contractor shall make auxiliary aids and services available upon request of the Potential Enrollee or Enrollee at no cost, and in a manner that takes into consideration the special needs of Potential Enrollees or Enrollees with disabilities or limited English proficiency.

(E) The Contractor shall make interpretation services, including oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign language (ASL), free of charge to each Enrollee.

(F) The Contractor shall notify its Enrollees that:

(1) oral interpretation is available for any language, and how to access those services;

(2) written translation is available in prevalent languages, and how to access those services; and

(3) auxiliary aids and services are available upon request at no cost for Enrollees with disabilities, and how to access those services.

(G) The Contractor shall provide adult Enrollees with written information on Advance Directives policies, and include a description of applicable state law. The information on Advance Directives provided to adult Enrollees must reflect changes in state law as soon as possible but no later than 90 calendar days after the effective date of the change.

(H) The Contractor shall use the Department-developed definition for the following terms: appeal; co-payment; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home health care; hospice services; hospitalization; hospital outpatient care; medically necessary; network; non-participating provider; participating provider; plan; physician services; preauthorization; premium; prescription drug coverage; prescription drugs; primary care provider; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

(I) The Contractor shall use Enrollee notices developed by the Department.

3.5.2 Determining Prevalent Language

The Contractor shall use the Eligibility Transmissions to determine prevalent non-English languages. A language is prevalent when it is spoken by five percent or more of the Contractor's enrolled population.

3.5.3 All Written Materials

(A) The Contractor shall provide all written materials for Potential Enrollees and Enrollees in an easily understood language and format, and in a font size no smaller than 12 point.

(B) The Contractor shall provide all written materials for Potential Enrollees and Enrollees in alternative formats upon request and at no cost, and in an appropriate manner that takes into consideration the special needs of Potential Enrollees or Enrollees with disabilities or limited English proficiency.

3.5.4 Written Materials Critical to Obtaining Services

(A) The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, Enrollee handbooks, Appeal and Grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular Service Area.

(B) The Contractor shall include taglines that:

- (1) are in the prevalent non-English languages in the State;
- (2) are in a conspicuously visible font size;
- (3) explain the availability of written translation or oral interpretation to understand the information provided at no cost;
- (4) provide information on how to request auxiliary aids and services and that they are provided at no cost; and
- (5) include the toll-free and the TTY/TDD telephone numbers of the Contractor's Member Services/customer service unit.

3.5.5 Enrollee Handbook

(A) The Contractor shall provide each Enrollee an Enrollee handbook, within a reasonable time after receiving notice of the Enrollee's enrollment.

(B) The Department shall develop a model Enrollee handbook and shall designate which areas the Contractor is allowed to customize. The Contractor shall use the model Enrollee handbook by the date specified by the Department.

(C) The Enrollee handbook shall contain information:

- (1) that enables the Enrollee to understand how to effectively use the Contractor's Managed Care Program;

- (2) on benefits provided by the Contractor;
- (3) on how and where to access any benefits provided by the Department, including any cost sharing, and how transportation is provided;
- (4) which details that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees that the service is not covered by the Contractor and how they can obtain information from the Department about how to access those services;
- (5) on the amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;
- (6) on the Contractor's procedures for obtaining benefits, including service authorization requirements and/or referrals for specialty care;
- (7) on the extent to which, and how, after-hours care is provided;
- (8) on how emergency care is provided;
- (9) regarding what constitutes an Emergency Medical Condition;
- (10) regarding what constitutes an Emergency Service;
- (11) that prior authorization is not required for Emergency Services;
- (12) that the Enrollee has the right to use any hospital or other setting for emergency care;
- (13) on cost sharing for services furnished by the Contractor, if any is imposed under the State Plan;
- (14) on the Post-stabilization Care Services rules set forth at 42 CFR 422.113(c);
- (15) on any restrictions on the Enrollee's freedom of choice among Network Providers;
- (16) on the extent to which, and how, Enrollees may obtain benefits from Non-Network Providers.
- (17) on time frames for offering first service for emergent, urgent and non-urgent care specified in Article 10.4.4 of this Contract.
- (18) on Enrollee rights and responsibilities, including the Enrollee's right to:
 - (i) receive information on beneficiary and plan information;
 - (ii) be treated with respect and with due consideration for the Enrollee's dignity and privacy;

(iii) receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

(iv) participate in decisions regarding the Enrollee's health care, including the right to refuse treatment;

(v) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;

(vi) if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of the Enrollee's medical records and request that they be amended or corrected;

(vii) be furnished health care services in accordance with access and quality standards; and

(viii) be free to exercise all rights and that by exercising those rights, the Enrollee shall not be treated adversely by the Contractor, its Network Providers, or the Department.

(19) on Grievance, Appeal, and State Fair Hearing procedures and timeframes developed by or described in a manner approved by the Department;

(20) on the Enrollee's (or the Enrollee's legal guardian's or other authorized representative's, or a provider's) right to:

(i) file Grievances and request Appeals; and

(ii) request a State Fair Hearing after the Contractor has made a determination on the Appeal which is adverse to the Enrollee;

(21) on the requirements and timeframes for filing a Grievance or requesting an Appeal;

(22) on the availability of assistance in the filing process for Grievances;

(23) on the availability of assistance in requesting Appeals;

(24) on the fact that, when requested by the Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Enrollee requests an Appeal or a State Fair Hearing within the timeframes specified for filing, and requests continuation of services within the required timeframe, and that the Enrollee may, consistent with state policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee;

(25) that Indian Enrollees may obtain Covered Services directly from an Indian Health Care Provider;

- (26) on how to exercise an Advance Directive;
- (27) on how to access auxiliary aids and services, including additional information in alternative formats or languages, at no cost;
- (28) regarding the toll-free telephone numbers for Member Services, medical management, and any other unit providing services directly to Enrollees;
- (29) on how to report suspected Fraud or Abuse;
- (30) that Enrollees may obtain Covered Services directly from an FQHC;
- (31) on Advance Directives policies, including a description of applicable state law;
- (32) that describes the transition of care policies for Potential Enrollees and Enrollees; and
- (33) on any other content required by the Department.

3.5.6 Enrollee Handbook Dissemination

The handbook information provided to the Enrollee is considered to be provided if the Contractor:

- (1) mails or causes to be mailed a printed copy of the information to the Enrollee's mailing address;
- (2) provides the information by email after obtaining the Enrollee's agreement to receive the information by email;
- (3) posts the information on its website and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- (4) provides the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3.5.7 Enrollee Handbook Review and Approval

(A) The Contractor shall submit its model Enrollee handbook based on the Department's model handbook for review and approval by the date specified by the Department.

(B) The Department shall notify the Contractor in writing of its approval or disapproval within 30 calendar days after receiving the Enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon timeframe, the Contractor may deem such materials approved by the Department.

3.5.8 Enrollee Notice of Significant Change

(A) After the Department has approved the Contractor's model Enrollee handbook, if the Contractor intends to make any change to its Enrollee handbook, including changes that would impact the information specified in Article 3.5.5 (C):

(1) the Contractor shall notify the Department in writing within 60 calendar days of the intended effective date of the change; and

(2) the Department shall, within 10 business days of the notification, determine if the change is significant and inform the Contractor of its decision.

(B) If the Department identifies a significant change that would impact the information specified in Article 3.5.5 (C), the Department shall notify the Contractor in writing within 60 calendar days of the intended effective date of the change.

(C) The Contractor shall provide each Enrollee written notice of any significant change in the information specified in the Enrollee handbook at least 30 days before the intended effective date of the change.

(D) The Department and the Contractor shall also mutually determine the timeframe for updating the Enrollee handbook to reflect the change.

3.5.9 Network Provider Directory

(A) For each of the provider types covered under the Contract, the Contractor shall make the following information on the Contractor's Network Providers available to the Enrollee in paper form upon request and in electronic form:

(1) names, as well as any group affiliations;

(2) street addresses;

(3) telephone numbers;

(4) website URLs, as appropriate;

(5) specialties, as appropriate;

(6) whether Network Providers will accept new Enrollees;

(7) cultural and linguistic capabilities of Network Providers, including languages (including ASL) offered by the Provider or a skilled medical interpreter at the Provider's office; and

(8) whether Network Providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

(B) The Contractor shall update the paper Network Provider directory at least:

(1) monthly, if the Contractor does not have a mobile-enabled electronic directory; or

(2) quarterly, if the Contractor has a mobile-enabled directory.

(C) The Contractor shall update the electronic Network Provider directory no later than 30 calendar days after the Contractor receives updated Provider information.

(D) The Contractor shall make the Network Provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary of Department of Health and Human Services.

3.5.10 Termination of Network Providers

The Contractor shall make a good faith effort to give written notice of termination of a Network Provider to each Enrollee who received his or her primary care, or was seen on a regular basis by, the terminated Provider. Notice to the Enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or within 15 calendar days after receipt or issuance of the termination notice.

3.6 Disenrollment

3.6.1 Disenrollment Initiated by Contractor

The Contractor may not request disenrollment of an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs (except when continued enrollment in the PMHP seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees).

Article 4: Benefits

4.1 General Provisions

4.1.1 Basic Standards

(A) The Contractor shall provide to Enrollees, directly or through arrangements with Providers, all Covered Services described in the State's Prepaid Mental Health Plan Waiver as promptly and continuously as is consistent with generally accepted standards of medical practice.

(B) The Contractor shall furnish all Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS as set forth in 42 CFR 440.230, and for Enrollees under the age of 21, as set forth in 42 CFR 440, Subpart B.

(C) The Contractor shall ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(D) The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Enrollee.

(E) The Contractor may place appropriate limits on a service on the basis of criteria applied under the State Plan such as Medical Necessity, or for the purpose of utilization control, provided:

- (1) the services furnished can reasonably be expected to achieve their purpose; and
- (2) the services supporting Enrollees with ongoing or chronic conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports.

4.1.2 Covered Services

(A) The Contractor shall administer Covered Services in a manner that is no more restrictive than the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the State Plan, and other state policies, procedures, and administrative rules.

(B) In accordance with 42 CFR 438.210 the Contractor shall administer Covered Services in a manner that takes into account:

- (1) services that address the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
- (2) the ability for an Enrollee to achieve age-appropriate growth and development;
- (3) the ability for an Enrollee to attain, maintain, or regain functional capacity; and
- (4) the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

4.2 Scope of Services

4.2.1 Scope of Covered Services

(A) The Contractor is responsible to arrange for all Covered Services listed in State's Prepaid Mental Health Plan Waiver.

(B) The Contractor is responsible for payment of Emergency Services 24 hours a day, 7 days a week whether the services were provided by a Network Provider or a Non-Network Provider and whether the service was provided inside or outside of the Contractor's Service Area.

(C) In addition to services covered under the State Plan or the State's Prepaid Mental Health Plan Waiver, the Contractor may cover services necessary for compliance with the requirements of subpart K of 42 CFR Part 438 only to the extent such services are necessary for compliance with 42 CFR 438.910.

(D) The services provided by Contractor shall be delivered in compliance with the requirements of Subpart K of 42 CFR Part 438 insofar as applicable.

(E) The Contractor shall provide the Department with non-quantitative treatment limitation assessment tools, surveys or any corrective action plans related to compliance with the Mental Health Parity and Addiction Equity Act of 2008 and all related regulations as requested by the Department within the timeframes requested by the Department.

4.2.2 Changes to Benefits

Amendments, revisions, or additions to the State Plan, the Prepaid Mental Health Plan Waiver or to state or federal regulations, guidelines, or policies, insofar as they affect the scope or nature of benefits available to a Medicaid Eligible Individual shall be considered incorporated by this Contract and the Contractor shall be required to provide those benefits to Enrollees. The Department will provide written notice to the Contractor of any amendments, revisions, or additions prior to implementation when feasible.

4.2.3 Court and Administrative Orders Regarding Benefits

The Contractor shall pay for benefits related to an Adverse Benefit Determination deemed eligible for payment pursuant to the terms of a court or administrative order.

4.3 Covered Services—Emergency Services

4.3.1 General Requirements

- (A) The Contractor is responsible for coverage and payment of Emergency Services as described by this Contract and by law.
- (B) The Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- (C) The Contractor shall inform Enrollees that access to Emergency Services is not restricted and that if an Enrollee experiences a medical emergency, that the Enrollee may obtain services from a Non-Network Provider without penalty.
- (D) The Contractor may not refuse to cover Emergency Services based on the Provider, hospital, or Fiscal Agent not notifying the Contractor of the Enrollee's screening and treatment within ten calendar days of presentation for Emergency Services.
- (E) The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Network Provider or a Non-Network Provider.
- (F) The Contractor's payment to a Non-Network Provider for Emergency Services shall not exceed the lower of the Non-Network Provider's usual and customary charge in effect at the time of service, the Medicaid fee-for-service fee schedule in effect at the time of service, or an amount agreed to by the Contractor and the Non-Network Provider.

4.3.2 Emergency Services, 24 Hours

- (A) The Contractor shall have the capability to provide or arrange for all Emergency Services, 24 hours each day, 7 days a week.

(B) The Contractor shall ensure that Enrollees have access by telephone on a 24-hour basis to a live voice or answering machine that will immediately page an on-call mental health professional.

4.3.3 Emergency Services in an Outpatient Hospital

With regard to Emergency Services delivered to Enrollees in an outpatient hospital, the Contractor is responsible to pay only for those services rendered by a psychiatrist. The Contractor is responsible for these services regardless of whether the psychiatrist rendering the services is a Non-Network Provider.

4.3.4 Payment Liability for Emergency Services

(A) An Enrollee who has had 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 Enrollee.

(B) When the Enrollee has an Emergency Medical Condition, the Contractor shall pay for both the screening examination and treatment services required to stabilize the Enrollee. Services required to stabilize an Enrollee includes all Emergency Services that are Medically Necessary to assure, within reasonable medical probability, that no material deterioration of the Enrollee's condition is likely to result from, or occur during, discharge of the Enrollee or transfer of the Enrollee to another facility.

(C) If there is a disagreement between a hospital Provider and the Contractor concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweighs the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own physicians with appropriate privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

4.3.5 Payment Liability in the Absence of a Clinical Emergency

The Contractor must pay for Emergency Services obtained by an Enrollee when the Enrollee had an Emergency Medical Condition but such condition did not result in the three outcomes specified in the definition of an Emergency Medical Condition. In such instances, the Contractor shall review the presenting symptoms of the Enrollee and determine whether the presenting symptoms were acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably have expected the absence of immediate medical attention to result in one of the three outcomes listed in the definition of an Emergency Medical Condition.

4.3.6 Payment Liability for Referrals

The Contractor may not deny payment for treatment obtained by an Enrollee when a representative of the Contractor instructs the Enrollee to seek emergency care.

4.4 Covered Services—Post-stabilization Care Services

4.4.1 General Requirements

The Contractor shall cover and pay for Post-stabilization Care Services in accordance with the guidelines found in 42 CFR 422.113(c). Generally, Post-stabilization Care Services begin when an Enrollee is admitted for an inpatient hospital stay after the Enrollee has received Emergency Services.

4.4.2 Pre-Approved Post-stabilization Care Services

The Contractor is financially responsible for Post-stabilization Care Services obtained by an Enrollee from a Network Provider or a Non-Network Provider that are pre-approved by a Contractor representative.

4.4.3 Other Contractor-Liable Post-stabilization Care Services

(A) The Contractor is financially responsible for Post-stabilization Care Services obtained within or outside the Contractor's network that are not pre-approved by a Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further Post-stabilization Care Services.

(B) The Contractor is financially responsible for Post-stabilization Care Services obtained within or outside of the Contractor's network that are not pre-approved by a Contractor representative but are administered to maintain, improve or resolve the Enrollee's stabilized condition if:

- (1) the Contractor does not respond to a request for pre-approval within one hour of the request;
- (2) the Contractor cannot be contacted; or
- (3) the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with the care of the Enrollee until a Contractor physician is reached, or one of the following criteria, found in 42 CFR 422.113(c)(3) is met:
 - (i) a Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
 - (ii) a Contractor physician resumes responsibility for the Enrollee's care;
 - (iii) a Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or
 - (iv) the Enrollee is discharged.

4.4.4 Limitation on Charges to Enrollees

The Contractor must limit charges to Enrollees for Post-stabilization Care Services to an amount no greater than that what the Contractor would charge the Enrollee if he or she had obtained the services through the Contractor. For purposes of cost sharing, Post-stabilization Care Services begin upon inpatient admission.

Article 5: Delivery Network

5.1 Availability of Services

5.1.1 Network Requirements

(A) The Contractor shall maintain and monitor a network of appropriate Network Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract for all Enrollees, including those with limited English proficiency or physical or mental disabilities. In establishing and maintaining the network of Network Providers the Contractor shall consider:

- (1) the anticipated Medicaid enrollment;
- (2) the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's Service Area;
- (3) the numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the Covered Services;
- (4) the number of Network Providers who are not accepting new Medicaid patients;
and
- (5) the geographic location of Network Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees.

(B) The Contractor shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities.

(C) The Contractor shall allow each Enrollee to choose a Network Provider to the extent possible and appropriate.

5.1.2 Second Opinions

The Contractor shall provide for a second opinion from a qualified Network Provider, or arrange for the Enrollee to obtain one outside the network, at no cost to the Enrollee.

5.1.3 Out of Network Services

(A) If the Contractor's network of Network Providers is unable to provide Covered Services under this Contract to a particular Enrollee, the Contractor shall adequately and timely cover these services using a Non-Network Provider for the Enrollee for as long as the Contractor is unable to provide them.

(B) The Contractor shall require Non-Network Providers to coordinate with the Contractor with respect to payment and ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the network.

5.1.4 Timely Access

(A) The Contractor and its Network Providers shall meet the Department's standards for timely access to care described in Article 10.4.

(B) The Contractor shall ensure its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee-For-Service enrollees, if the Network Provider serves only Medicaid Enrollees.

(C) The Contractor shall make all Covered Services available 24 hours a day, 7 days a week, when Medically Necessary.

5.1.5 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements found in Article 10.4, and shall monitor its Network Providers regularly to determine compliance by Network Providers. If there is failure to comply, the Contractor shall take corrective action.

5.1.6 Time and Distance Standards

(A) The Contractor shall implement the provider network adequacy time and distance standards specified in Table 2 for adult and pediatric Covered Services. The standards vary for urban, rural and frontier counties of the State. Table 1 includes the designation of each county as urban, rural, or frontier. The Contractor shall apply the standards in Table 2 according to each of its covered county's designation in Table 1. The Contractor shall apply the standards as applicable to adult mental health providers, adult substance use disorder providers, pediatric mental health providers and pediatric substance use disorder providers.

Table 1 – County Designation

Urban Counties	Rural Counties	Frontier Counties
Davis	Cache	Beaver
Salt Lake	Carbon	Box Elder
Utah	Iron	Daggett
Weber	Morgan	Duchesne
	Sanpete	Emery
	Sevier	Garfield
	Summit	Grand
	Wasatch	Juab
	Washington	Kane
		Millard
		Piute
		Rich
		San Juan
		Tooele
		Uintah
		Wayne

Table 2 – Network Adequacy Standards

Urban Counties	Rural Counties	Frontier Counties
90% of members must have access to Network Providers within 10 miles or 15 minutes	80% of members must have access to Network Providers within 35 miles or 45 minutes	75% of members must have access to Network Providers within 60 miles or 70 minutes

(B) If the Contractor is unable to meet the network adequacy standards, the Contractor may request an exception to these standards. The Department has sole discretion to allow for any exception to the network adequacy standards. A request for exception to these standards must be in writing and must include:

- (1) the specific exemption the Contractor is requesting;
- (2) the steps taken by the Contractor to comply with the network adequacy requirements before requesting the exception; and
- (3) a description of the Contractor’s plan to adequately provide Covered Services in the area where the exemption is requested.

5.2 Subcontracts and Agreements with Providers

5.2.1 General Requirements

(A) The Contractor shall maintain the ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, notwithstanding any relationship(s) that the Contractor may have with any Subcontractor.

(B) If any of the Contractor’s activities or obligations under this Contract are delegated to a Subcontractor, the Contractor shall ensure that:

- (1) the activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Contractor and the Subcontractor; and
- (2) the contract or written arrangement between the Contractor and the Subcontractor provides for the revocation of the delegation of activities or obligations, or specifies other remedies in instances where the Department or the Contractor determines that the Subcontractor has not performed satisfactorily.

(C) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to:

- (1) comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.
- (2) agree that the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract.
- (3) make available, for the purposes of an audit, evaluation, or inspection by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Enrollees.
- (4) agree that the right to audit by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
- (5) agree that if the Department, CMS, or the Department of Health and Human Services Inspector General determines that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

5.2.2 Agreements with Providers and Subcontractors

(A) The Contractor shall, at the time the Contractor enters into an agreement with a Provider or a contract with a Subcontractor, inform the Provider or Subcontractor of the following:

- (1) the Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424;
- (2) the Aggrieved Person's right to file Grievances and request Appeals and the requirements and timeframes for filing;
- (3) the availability of assistance with filing Grievances and requesting Appeals;
- (4) the Aggrieved Person's right to request a State Fair Hearing after the Contractor has made a determination on the Appeal request that is adverse to the Enrollee; and

(5) if the Contractor makes an Adverse Benefit Determination to reduce, suspend or terminate services:

(i) the Enrollee, the Enrollee's legal guardian or other authorized representative has the right to request that the services be continued pending the outcome of the Appeal or State Fair Hearing if the Enrollee requests continuation of services within the required time frame; and

(ii) if the Appeal or State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of services.

(B) The Contractor shall ensure its Providers and Subcontractors shall not bill Enrollees for Covered Services any amount greater than would be owed if the Provider or Subcontractor provided the Covered Services directly.

(C) The Contractor's written agreements with its Providers and Subcontractors shall contain provisions stating:

(1) that if the Provider or Subcontractor becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Provider or Subcontractor; and

(2) that the Enrollee shall not be held liable for Covered Services provided to the Enrollee for which:

(i) the Department does not pay the Contractor, or

(ii) the Department or the Contractor does not pay the individual or Provider that furnished the services under a contractual, referral or other arrangement.

5.2.3 Additional Network Provider Requirements

(A) In accordance with Article 6.6, if the Contractor has a Physician Incentive Plan with a physician or physician group, the Contractor shall ensure these Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act.

(B) The Contractor shall ensure its Network Providers and staff are knowledgeable about methods to detect domestic violence, about mandatory reporting laws when domestic violence is suspected, and about resources in the community to which patients can be referred.

(C) The Contractor shall ensure its Network Providers are aware of the Contractor's QAPIP and activities. The Contractor's Network Provider agreements shall include a requirement securing cooperation with the Contractor's QAPIP and activities and shall allow the Contractor access to the medical records of Enrollees being treated by Network Providers.

(D) All physicians who provide services under this Contract shall have a unique identifier in accordance with the system established under Section 1173(b) of the Social Security Act and in accordance with the Health Insurance Portability and Accountability Act.

(E) The Contractor shall ensure its Network Providers are enrolled as Utah Medicaid providers.

(F) The Contractor shall ensure its Providers who prescribe medication are enrolled with the Department otherwise the pharmacy Claims related to a Provider will not be paid.

(G) The Contractor shall ensure its Network Providers are aware of the requirements of Articles 6.1.3 and 6.1.4 regarding reporting requirements of potential Fraud, Waste or Abuse.

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

(A) The Department shall screen, enroll, and periodically revalidate all Network Providers as Medicaid providers.

(B) The Contractor shall make a payment only to a Provider who is enrolled with the Department except when the Provider is:

- (1) a Non-Network Provider under a single case agreement;
- (2) an emergency provider that does not meet the definition of a Network Provider per 42 CFR 439.2: or
- (3) a Network Provider pending enrollment with the Department per 438.602(b)(2).

(C) The Contractor may execute Network Provider agreements for up to 120 calendar days pending the outcome of the Department's screening and enrollment process.

(D) The Contractor must terminate a Network Provider immediately when:

- (1) the Department notifies the Contractor that the Network Provider cannot be enrolled; or
- (2) the Provider notifies the Contractor that the Provider has been notified by the Department that the Provider cannot be enrolled; or
- (3) one 120-day period has expired without enrollment of the Provider by the Department.

(E) The Contractor shall notify affected Enrollees and transition them to other appropriate Providers when the Contractor terminates a Network Provider agreement.

5.3.2 Network Provider Selection

(A) The Contractor shall implement written policies and procedures for selection and retention of Network Providers and those procedures include, at minimum, the requirements found in this Contract.

(B) The Contractor shall comply with any additional Network Provider selection requirements required by the Department.

5.3.3 Credentialing and Re-Credentialing Policies and Procedures

(A) Pursuant to 42 CFR 438.214(b)(2), the Contractor shall have written policies and procedures for credentialing potential Network Providers and re-credentialing Network Providers.

(B) The Contractor's written policies and procedures shall follow the Department's policies that require:

- (1) Network Providers to complete the Contractor's written applications;
- (2) procedures for assuring that potential and current Network Providers are appropriately credentialed;
- (3) primary source verification of licensure and disciplinary status by the State of Utah and other states; and
- (4) procedures for viewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension, or exclusion.

5.3.4 Timeframe for Re-Credentialing

The Contractor shall have a recredentialing process for Network Providers that is completed at least every three years, and that updates information obtained during the initial credentialing process.

5.3.5 Notifications

The Contractor shall have procedures for notifying DOPL when it suspects or has knowledge that a Provider has violated professional licensing statutes, rules, or regulations.

5.3.6 Documentation

The Contractor shall maintain documentation of its credentialing and re-credentialing activities. Upon request from the Department, the Contractor shall demonstrate that its Network Providers are credentialed and re-credentialed following Contractor's written credentialing and re-credentialing policies and procedures in accordance with 42 CFR 438.214.

5.3.7 Non-Inclusion of Providers

(A) The Contractor shall report to the Department when a Provider is denied Network Provider status. Such denial can include when a Provider is denied admission to the Contractor's provider panel, is removed from the Contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of DOPL's regulations, and allegations of Fraud, Waste or Abuse.

(B) The Contractor shall electronically submit information relating to the non-inclusion of Providers to the Department within 30 calendar days of the non-inclusion action using the Department-specified form.

(C) The Contractor shall not report non-inclusion of Providers when due to non-substantive issues. Non-substantive issues include instances where the provider fails to complete the credentialing process or the Contractor has sufficient network capacity.

5.3.8 Nondiscrimination

(A) Consistent with 42 CFR 438.214 and 42 CFR 438.12, the Contractor's Provider selection policies and procedures must not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment.

(B) Pursuant to 42 CFR 438.12, the Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of that Provider's license or certification under applicable state law, solely on the basis of the Provider's license or certification. This may not be construed to mean that the Department:

(1) requires the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees;

(2) precludes the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) precludes the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

(C) If the Contractor declines to include individuals or groups of Providers in its network, it shall give the affected Providers written notice of the reason for its decision.

5.3.9 Federally Qualified Health Centers

(A) The Contractor shall not restrict an Enrollee's right to obtain FQHC services outside the PMHP through FFS.

(B) If the Contractor has a Network Provider agreement with an FQHC and has agreed to pay the FQHC, the Contractor shall reimburse the FQHC an amount not less than what the Contractor pays comparable Providers that are not FQHCs.

5.4 Payment of Provider Claims

5.4.1 General Requirements

(A) The Contractor shall pay Providers on a timely basis consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act and the implementing federal regulations at 42 CFR 447.45 and 42 CFR 447.46 unless the Contractor and the Network Provider have established an alternative payment schedule.

(B) The Contractor shall pay 90 percent of all Clean Claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 calendar days of receipt.

(C) The Contractor shall pay 99 percent of all Clean Claims from practitioners, who are in individual or group practice or who practice in shared facilities, within 90 calendar days of the date of receipt.

(D) The date of receipt is the date the Contractor receives the Claim as indicated by its date stamp on the Claim.

(E) The date of payment is the date of the check or other form of payment.

5.5 Prohibitions on Payment

5.5.1 Availability of FFP

(A) Pursuant to Section 1903(i)(2), 42 CFR 438.808, 1001.1901(c), and 1002.3(b), FFP is not available for any amounts paid to the Contractor if:

(1) the Contractor is controlled by a sanctioned individual as described in Section 1128(b)(8) of the Social Security Act;

(2) the Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management, or provision for medical services either directly or indirectly, with:

(i) an individual Convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act;

(ii) any individual or entity that is (or is affiliated with a person/entity that is) debarred, Suspended, or Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(iii) any individual or entity that is Excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Social Security Act.

(3) the Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

(i) any individual or entity Excluded from participation in Federal Health Care Programs under section 1128 or 1128A of the Social Security Act;

(ii) any individual or entity that is (or is affiliated with a person/entity that is) debarred, Suspended, or Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-

procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(iii) any entity that would provide those services through an individual or entity debarred, Suspended, or Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Social Security Act.

(B) The Parties understand and agree that the Department must ensure that no payment is made to a Network Provider other than by the Contractor for Covered Services, except when these payments are specifically required to be made by the Department in Title XIX of the Social Security Act, in 42 CFR, or when the Department makes direct payments to Network Providers for graduate medical education costs approved under the State Plan.

5.6 Network Provider Practice Guidelines

5.6.1 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall adopt practice guidelines. The guidelines shall:

- (1) be based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- (2) consider the needs of the Contractor's Enrollees;
- (3) be adopted in consultation with Network Providers; and
- (4) be reviewed and updated periodically as appropriate.

(B) The Contractor shall disseminate the practice guidelines to all affected Network Providers and, upon request, to Enrollees.

(C) The Contractor's decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply shall be consistent with the practice guidelines.

(D) The Contractor shall use the American Society of Addiction Medicine (ASAM) level of care placement criteria for management of substance use disorder services.

Article 6: Program Integrity Requirements

6.1 Fraud, Waste, and Abuse

6.1.1 General Requirements

(A) Pursuant to 42 CFR 438.608, the Contractor or Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of Claims, shall implement and maintain arrangements or procedures, including a mandatory compliance program, that are designed to guard against Fraud, Waste, and Abuse on the part of the Providers, Enrollees, and other patients who falsely present themselves as being Medicaid eligible.

(B) The Contractor or Subcontractor shall have a written compliance plan designed to identify and refer suspected Fraud, Waste, and Abuse activities. The Contractor shall submit the compliance plan to the Department upon the Department's request. The compliance plan shall be subject to the Department's approval.

(C) The Contractor shall cooperate and coordinate with the Department, the Utah Office of Inspector General of Medicaid Services (Utah OIG), and the MFCU in any Waste, Fraud, and Abuse activities and investigations.

6.1.2 Specific Requirements for Contractor's Management Arrangements or Procedures

The Contractor or Subcontractor shall have a written compliance plan to guard against Fraud, Waste, and Abuse that includes:

- (1) written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements;
- (2) the designation of a compliance officer responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract, and who reports directly to the Chief Executive Officer and the board of directors;
- (3) the establishment of a regulatory compliance committee that is on the board of directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract;
- (4) a system for training and education for the compliance officer, the Contractor's senior management, and the Contractor's employees on the federal and state standards and requirements under this Contract
- (5) effective lines of communication between the compliance officer and the Contractor's employees;
- (6) enforcement of standards through well-publicized disciplinary guidelines;
- (7) establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as they are raised, investigation of potential compliance problems as identified in the

course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract;

(8) provisions for prompt reporting to the Department of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, Waste, or Abuse;

(9) a provision for prompt notification to the Department when it receives information about changes in an Enrollee's circumstances that may affect eligibility including changes in residence or death of an Enrollee;

(10) a provision for notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect that Network Provider's eligibility to participate in the PMHP, including the termination of the Network Provider agreement with the Contractor;

(11) as detailed in Article 6.1.6, provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification processes on a regular basis;

(12) as detailed in Article 6.2, provision for written policies for all employees of the Contractor, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers;

(13) as detailed in Article 6.1.3, provision for the prompt referral of any potential Fraud, Waste, or Abuse that the Contractor identifies to the Department, the Utah OIG, or MFCU; and

(14) as detailed in Article 6.1.5, provision for the Contractor's suspension of payments to a Network Provider for which the Department determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23.

6.1.3 Reporting Potential Provider-Related Fraud, Waste, and Abuse

(A) Pursuant to Utah Code Ann. 63A-13-101 et seq., if the Contractor or a Provider becomes aware of potential Provider-related Fraud, Waste, or Abuse, the Contractor or the Provider shall report the incident in writing to the Utah OIG (mpi@utah.gov), or to MFCU (MFCUComplaints@agutah.gov), and shall also submit a copy of the report to the Department (mc-fwa@utah.gov).

(B) The Contractor or Provider shall submit reports of potential Provider-related Fraud, Waste, or Abuse, within 15 business days of detection of the incident of potential Provider-related Fraud, Waste, or Abuse, subject to the exception for Waste in Utah Code Ann. 63A-13-501(1)(b).

(C) The Contractor or Provider shall include in the report:

- (1) name and identification number of the suspected individual;
- (2) source of the complaint (if anonymous, indicate as such);
- (3) type of Provider or type of staff position, if applicable;
- (4) nature of complaint;
- (5) approximate dollars involved, if applicable and
- (6) the legal and administrative disposition of the case, if any, including actions taken by law enforcement to whom the case has been referred.

(D) The Contractor shall submit to the Department, using the Department-specified format, a quarterly report that includes:

- (1) in accordance with 42 CFR 455.17(a), the number of complaints of Fraud, Waste, or Abuse that warranted preliminary investigation;
- (2) the number of incidents of potential Fraud, Waste, or Abuse reported to the OIG or MFCU in accordance with Utah Code Ann. 63A-13 et seq.; and
- (3) the names of Providers against which the Contractor has taken any adverse action for Fraud, Waste or Abuse, and a description of the adverse action taken.

(E) The Contractor shall refer to Article 11.1.6 regarding the recovery of Overpayments.

6.1.4 Reporting Medicaid Member-Related Fraud, Waste, and Abuse

If the Contractor or a Provider becomes aware of potential Medicaid member Fraud related to the Medicaid-member's eligibility for Medicaid (such as, the recipient misrepresented facts in order to become or maintain Medicaid eligibility), the Contractor or Provider shall report the potential Medicaid member Fraud to the Utah Department of Workforce Services. All other types of potential Fraud and all types of potential Medicaid member Waste or Abuse related to the Medicaid program shall be reported to the Utah OIG and to the Department.

6.1.5 Obligation to Suspend Payments to Providers in Cases of Fraud

(A) The Contractor shall develop policies and procedures to comply with 42 CFR 455.23.

(B) The Contractor shall contact MFCU prior to suspending payments.

(C) If the Department suspends payments to a Provider, and the Department notifies the Contractor, the Contractor shall also suspend payments to that Provider until the Department lifts the suspension.

6.1.6 Service Verification

(A) The Contractor shall have policies and procedures to verify that services billed by Providers were received by the Contractor's Enrollees. The Contractor's written policies and procedures must include that:

(1) annually, the Contractor shall randomly select a minimum of 50 individual Enrollees who received a Covered Service during the SFY for service verification; and

(2) the Contractor shall keep a record of each Enrollee contacted for service verification that includes:

(i) the Enrollee's name and Medicaid ID number;

(ii) the date of each contact (if a prior attempt was unsuccessful);

(iii) the method of contact;

(iv) whether the Enrollee responded to the contact;

(v) whether the Enrollee indicated he or she obtained the service; and

(3) the Contractor shall keep copies of correspondence.

(B) The Contractor shall keep sufficient documentation to allow the Department to verify that service verifications have been performed.

6.1.7 Subrogation of Claims Arising from Fraud

The Contractor agrees to be subrogated to the State for any and all claims Contractor has or may have against pharmaceutical companies, retailers, Providers, or other Subcontractors, medical device manufacturers, laboratories or durable medical equipment manufacturers in the marketing and pricing and quality of their products. The Contractor shall not be entitled to any portion of the recovery obtained by MFCU.

6.2 False Claims Act

6.2.1 General Requirements

(A) In accordance with Section 6032 of the Deficit Reduction Act of 2005, if the Contractor receives annual payments of at least \$5,000,000.00 from the Department, the Contractor shall establish written policies and procedures for all of its employees (including management) and its contractors or agents which comply with the Act.

(B) For purposes of Article 6.2, the following definitions apply:

(1) **Employee:** includes any officer or employee of the Contractor.

(2) **Agent or contractor:** includes any contractor, Subcontractor, agent or other person which or who, on behalf of the Contractor, furnishes or otherwise authorizes

the furnishing of Medicaid Covered Services, performs billing or coding functions, or is involved in monitoring of health care provided by or on behalf of the Contractor.

6.2.2 Information Required in False Claims Act Policies

(A) The written policies shall provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false Claims and statements established under Chapter 38 of Title 31, United States Code, any state laws pertaining to civil or criminal penalties for false Claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs.

(B) The Contractor shall include as part of its written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

6.2.3 Dissemination of False Claims Act Policies and Procedures

(A) To the extent the False Claims Act applies to the Contractor, the Contractor shall have written procedures for disseminating to its employees, contractors and agents its False Claims Act Policies.

(B) The Contractor shall require that its Network Providers comply with the Contractor's False Claims Act policies and procedures.

(C) The Contractor shall use all reasonable efforts, including provider attestations, to ensure that its Network Providers are either disseminating the Contractor's or equivalent False Claims Act policies and procedures to the Network Provider's employees and agents.

6.2.4 Employee Handbook

If the Contractor has an employee handbook, the Contractor shall include:

(1) a specific discussion of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false Claims and statements established under Chapter 38 of Title 31, United States Code, any state laws pertaining to civil or criminal penalties for false Claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs;

(2) the rights of employees to be protected as whistleblowers; and

(3) the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

6.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

6.3.1 General Requirements

(A) The Contractor shall comply with Section 1932(d) of the Social Security Act and 42 CFR 438.610:

(1) The Contractor shall not knowingly have a director, officer, partner, a Subcontractor as governed by 42 CFR 438.230, or a person with beneficial ownership of 5% or more of the Contractor's equity who is:

(i) debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or

(ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

(2) The Contractor shall not knowingly have a Network Provider or an employment, consulting, or any other agreement with a person for the provision of items or services that are significant and material to the Contractor's obligations to the Department who is:

(i) debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or

(ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

(B) In accordance with 42 CFR 438.610(b), the Contractor may not have a relationship with an individual or entity that is Excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.

6.3.2 Screening for Prohibited Affiliations

(A) The Contractor shall maintain written policies and procedures for conducting routine searches for prohibited affiliations.

(B) The Contractor shall screen the following relationships to ensure it has not entered into a prohibited affiliation with:

- (1) directors, officers, or partners of the Contractor (including the Contractor's Board of Directors). If an elected official is legally required to serve on the Board of Directors (e.g., mayor, county council member, etc.), and it is determined that a prohibited affiliation exists, then the Contractor shall prohibit that elected official from participating in any discussions or decisions related to this Contract or the terms therein;
- (2) Subcontractors as governed by 42 CFR 438.230;
- (3) persons with beneficial ownership of 5 percent or more in the Contractor's equity;
- (4) Network Providers; and
- (5) persons with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with the Department.

(C) Before entering into a relationship with the individuals or entities listed in Article 6.3.2 (B)(1), (2), (3), (4), and (5), the Contractor shall, at minimum:

- (1) conduct searches of the SAM and LEIE databases, and any other databases required by the Department, to determine if individuals listed in Article 6.3.2(B)(1), (2), (3), (4), and (5) are debarred, Suspended, or otherwise Excluded; and
- (2) maintain documentation showing that such searches were conducted.

(D) If the individuals or an entity listed in Article 6.3.2 (B)(1), (2), (3), (4), and (5) are not found in the database search, the Contractor is required to determine if the individual or entity is an affiliate of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

- (1) To determine if those listed in Article 6.3.2(B)(1), (2), (3), (4), and (5) are an affiliate of a person who is debarred, Suspended, or otherwise Excluded, the Contractor shall obtain attestations.
- (2) The Department's Prohibited Affiliation Attestation form includes a statement that if the individual or entity completing the form subsequently becomes an affiliate of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the individual must notify the Contractor within 30 calendar days of the discovery and complete a new attestation form.

(E) If the Contractor determines based on database search results or from the attestation forms that a prohibited affiliation would result, the Contractor may not enter into the relationship.

(F) The Contractor shall conduct monthly searches of the required databases to determine if those listed in Article 6.3.2 (B)(1), (2), (3), (4), and (5) have been added to the databases. The Contractor shall keep records showing that these monthly searches were conducted.

(G) If an entity other than the Contractor (for example, the board of directors) has the authority to enter into a relationship described in Article 6.3.2 (B)(1), (2), (3), (4), and (5) of this Contract, then the Contractor or the other entity shall conduct the required database searches and obtain the requisite attestations. Thereafter the Contractor or other entity shall conduct the monthly searches to determine if those individuals or entities listed in Article 6.3.2 (B)(1), (2), (3), (4), and (5) have been added to the databases. The party conducting the search shall keep records showing that these monthly searches were conducted.

(H) The Contractor shall not be required to use the Department's Prohibited Affiliation Attestation form if the Contractor has developed an alternative method to screen and report Prohibited Affiliations as described in Article 6.3. The Contractor shall send a written request to the Department describing the alternative method. The use of an alternative method must be approved of by the Department in writing.

6.3.3 Reporting Prohibited Affiliations

(A) In the event that the Contractor determines that it is not in compliance and has entered into a prohibited affiliation of the type described in Article 6.3.2 of this Contract, the Contractor must immediately, and no later than 30 calendar days, notify the Department. Notification to the Department shall be by email and shall include the name, Social Security Number as applicable, and type of relationship the person or entity has with the Contractor. For Excluded Providers, in accordance with Article 6.4.2 (I), the Contractor shall notify the Department of the Exclusion by electronically submitting the information on the Department's Disclosure of Excluded Provider Form.

(B) If the Contractor obtains a prohibited affiliation attestation form from an individual or entity stating that the individual or entity is an Affiliate of a person who has been 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 pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall provide an electronic copy of the attestation form to the Department no later than 30 calendar days from the date of the individual provided the attestation to the Contractor.

(C) To ensure compliance with 42 CFR 1002.203, the Department, after having been notified of the Contractor's noncompliance:

- (1) shall notify the Secretary of the United States' Department of Health and Human Services ("Secretary") of the noncompliance;

(2) may continue the existing Contract with the Contractor unless the Secretary (in consultation with the United States' Department of Health and Human Services Inspector General) directs otherwise; and

(3) may not renew or otherwise extend the duration of an existing contract with the Contractor unless the Secretary (in consultation with the United States' Department of Health and Human Services Inspector General) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

6.4 Excluded Providers

6.4.1 Definition of Excluded Providers

In accordance with 42 CFR 438.214(d), the Contractor may not employ or contract with Providers who are Excluded from participation in Federal Health Care Programs under either Section 1128 or 1128(A) of the Social Security Act.

6.4.2 Screening for Excluded Providers

(A) The Contractor shall maintain written policies and procedures for conducting routine searches of the SAM and LEIE, and any other databases required by the Department, to determine that the Providers are not Excluded Providers.

(B) Before contracting with or employing a Provider, and as part of the credentialing and recredentialing processes, the Contractor shall search the SAM and LEIE databases, and any other databases required by the Department, to ensure that the Providers are not Excluded Providers.

(C) The Contractor shall conduct monthly searches of the SAM and LEIE databases, and any other databases required by the Department, to determine that the Providers are not Excluded Providers and maintain documentation showing that such searches were conducted.

(D) For Providers that are Medicare-certified or are Medicaid Providers, the Contractor need search only for the Provider's name (e.g., the name of a subcontracted hospital). For Providers that are not Medicare-certified or are not Medicaid Providers, the Contractor shall search for the Provider and its director.

(E) Once the Contractor has credentialed the potential Provider and enters into a Provider agreement, the Contractor may delegate:

(1) searches of the Provider's director; and/or

(2) searches of the Provider's providers who deliver Covered Services incident to the Provider's obligations under its agreements with the Contractor.

(F) The Contractor shall perform searches not delegated to the Provider and shall maintain documentation that such searches were conducted.

(G) If the Contractor delegates the Exclusion searches to a Network Provider, the Contractor shall include this requirement in its written Provider agreement. The Contractor shall require the Provider to have written policies and procedures for conducting the delegated searches, for maintaining documentation that such searches were conducted, and for reporting any Exclusion findings to the Contractor within 30 calendar days of the discovery.

(H) If the Contractor delegates Exclusion monitoring to a Provider, the Contractor shall have written monitoring policies and procedures to ensure its Providers are conducting the Exclusion searches in accordance with the delegation agreement.

(I) Within 30 calendar days of either identifying an Excluded Provider or receiving Exclusion information from a Provider, the Contractor shall notify the Department of the Exclusion by electronically submitting the information on the Department's Disclosure of Excluded Provider Form.

6.4.3 Excluded Provider Payment Prohibition

If the Contractor employs or contracts with an Excluded Provider, the Contractor is prohibited from paying for any Claims for Covered Services to Enrollees which were furnished, ordered, or prescribed by Excluded Providers except as allowed by 42 CFR 1001.1901(c).

6.5 Disclosure of Ownership and Control Information

6.5.1 Disclosure Information

(A) Using the Department-specified disclosure form, and in accordance with 42 CFR 455.104, the Contractor, if organized as a corporation, shall provide disclosures for each Person with an Ownership or Control Interest in the Contractor.

(B) The disclosures for Persons with an Ownership or Control Interest shall include:

- (1) the person's name and address of any Person (individual or corporation) with an Ownership or Control Interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location and the P.O. Box address;
- (2) date of birth and Social Security Number (in the case of an individual);
- (3) other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent or more interest;
- (4) whether the Person (individual or corporation) with an Ownership or Control Interest in the Contractor is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling;
- (5) whether the Person (individual or corporation) with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent or more

interest is related to another person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling; and

(6) the name of any Other Disclosing Entity (or Fiscal Agent or Managed Care Entity) in which an owner of the Contractor has an ownership or control interest.

(C) Using the Department-specified form, and in accordance with 42 CFR 455.104, the Contractor shall provide disclosures of Managing Employees that include the name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

(D) Government-owned Entities - If the Contractor is government-owned, the Contractor shall disclose anyone meeting the definition of a Managing Employee, and would only need to disclose board members if a board member meets the definition of a Managing Employee.

(E) Non-Profit Entities

(1) If the Contractor is a non-profit entity and organized as a corporation, the Contractor shall submit disclosures in accordance with Article 6.5.1 (A);

(2) If the Contractor is a non-profit entity but not a corporation, the Contractor shall submit Managing Employee disclosures for all of the Contractor's individuals who meet the definition of a Managing Employee.

(F) Officers/Directors - Corporations Only

(1) Persons with an Ownership or Control Interest in the Contractor include officers and directors only if the Contractor is organized as a corporation. Corporations include for-profit corporations, non-profit corporations, closely-held corporations, limited liability corporations, and any other type of corporation authorized under State law. All officers and directors shall provide disclosures specified in Article 6.5.1(A).

(2) If the Contractor is organized as a corporation, the term director refers to members of the board of directors. In such instances, if the Contractor has a director of finance who is not a member of the board of directors, the individual would not need to be disclosed as a director/board member. To the extent the individual meets the definition of a Managing Employee, the Contractor shall disclose the individual as a Managing Employee.

(3) The Contractor shall disclose all officers and directors regardless of the number and even if they serve in a voluntary capacity.

(4) If the Contractor is a non-profit corporation and has trustees instead of officers or directors, the Contractor shall disclose the trustees in accordance with Article 6.5.1(A).

(5) The Contractor shall only disclose officers and directors of the Contractor. If the Contractor has indirect owner(s), the Contractor need not disclose the officers and directors of the indirect owner(s). If the indirect owner(s)' officers, directors or board

members also serve as the Contractor's officers, directors or board members, then the Contractor shall disclose the indirect owner(s)'s officers, directors or board members in accordance with Article 6.5.1(A).

(6) Partners

(i) The Contractor shall disclose all general and limited partnership interests, regardless of the percentage.

(ii) The Contractor shall only disclose partnership interest in the Contractor. The Contractor need not report partnership interests in the Contractor's indirect owner(s). If the partnership interest in the indirect owner(s) results in a greater than five percent indirect ownership interest in the Contractor, this indirect ownership interest must be disclosed in accordance with Article 6.5.1(A).

(G) Disclosure by Individuals in Other Capacity - Although an individual or entity may not qualify as an officer, director, or partner, and need not be disclosed as a Person with an Ownership or Control Interest in the Contractor, the party may need to be disclosed as a Managing Employee in accordance with Article 6.5.1(C).

6.5.2 Reporting Timeframes

(A) The Contractor shall electronically submit the Department's Managed Care Entity Disclosure Form:

(1) upon the Contractor submitting a proposal in accordance with state's procurement process;

(2) upon the Contractor executing the Contract with the Department;

(3) upon renewal or extension of the Contract;

(4) within 35 calendar days after any change in Persons with Ownership or Control Interest; and

(5) within 35 calendar days after any change in Managing Employees.

(B) The Department shall review the disclosures submitted by the Contractor.

6.5.3 Consequences for Failure to Provide Disclosures

FFP is not available in payments made to the Contractor if the Contractor or its Subcontractor performing administrative functions fails to disclose ownership or control or Managing Employee information as required by Article 6.5.

6.6 Disclosure of Physician Incentive Plans

6.6.1 General Requirements

The Contractor shall comply with the requirements set forth in 42 CFR 422.208 and 422.210.

6.6.2 Prohibition

In accordance with 42 CFR 422.208, the Contractor may operate a Physician Incentive Plan only if the Contractor makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Covered Services furnished to any particular Enrollee. Indirect payments may include offerings of monetary value (such as stock offerings or waivers of debt) measured in the present or future.

6.6.3 Reporting Requirements

(A) The Contractor shall notify the Department if the Contractor plans to operate a Physician Incentive Plan.

(B) To determine whether the incentive plan complies with the regulatory requirements, the Contractor shall report to the Department:

- (1) whether services not furnished by the physician or physician group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group;
- (2) the type of incentive arrangement (e.g., withhold, bonus, Capitation arrangement, etc.);
- (3) the percent of withhold or bonus, if applicable;
- (4) the panel size, and if Enrollees are pooled, the method used;
- (5) if the physician or physician group is at substantial financial risk, proof the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss; and
- (6) if required to conduct Enrollee surveys, the survey results.

6.6.4 Substantial Financial Risk

If the physician/group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual Enrollee surveys.

6.6.5 Information to Enrollees

The Contractor shall provide information on its Physician Incentive Plan to any Enrollee upon request. If the Contractor is required to conduct Enrollee surveys, the Contractor shall disclose the survey results to Enrollees upon request.

Article 7: Authorization of Services, Notice of Adverse Benefit Determination

7.1 Service Authorization and Notice of Adverse Benefit Determination

7.1.1 Policies and Procedures for Service Authorization Requests

(A) If requiring service authorizations, the Contractor shall establish and follow written policies and procedures for processing requests for initial and continuing authorization of Covered Services.

(B) The Contractor shall implement mechanisms to ensure consistent application of review criteria for service authorization decisions and consult with the requesting Provider when appropriate.

(C) The Contractor shall require that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Enrollee's medical, behavioral health, or long-term services and supports needs.

(D) The Contractor shall notify the requesting Provider, and give the Enrollee written notice of any decision to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider need not be in writing.

(E) The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Covered Services to any Enrollee.

7.1.2 Timeframes and Procedures for Standard Service Authorizations

(A) When making standard service authorization approvals the Contractor shall make a decision and provide notice to the Enrollee and Provider as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the receipt of the request for Service Authorization Request.

(B) The Contractor may extend the timeframe for making the decision by up to an additional 14 calendar days if:

(1) the Enrollee or the Provider requests an extension; or

(2) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's best interest.

(C) If the Contractor extends the timeframe for making standard service authorization decisions the Contractor shall:

(1) give the Enrollee written notice of the reason for the decision to extend the timeframe;

- (2) inform the Enrollee of the right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and
- (3) issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.3 Timeframes and Procedures for Denying All or Part of a Service Authorization Request

(A) If the Contractor denies a Service Authorization Request, or authorizes a requested service in an amount, duration or scope that is less than requested, the Contractor shall make the decision and give a Notice of Adverse Benefit Determination to the Enrollee as expeditiously as the Enrollee's health condition requires it, but no later than 14 calendar days from receipt of the Service Authorization Request. The Contractor shall also notify the requesting Provider, although the notice need not be in writing.

(B) The Contractor may extend the timeframe for making the decision by up to an additional 14 calendar days if:

- (1) the Enrollee or the Provider requests an extension; or
- (2) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's best interest.

(C) If the Contractor extends the timeframe for making standard service authorization decisions the Contractor shall:

- (1) give the Enrollee written notice of the reason for the decision to extend the timeframe;
- (2) inform the Enrollee of the right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and
- (3) issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.4 Timeframes and Procedures for Expedited Service Authorization Decisions

(A) For cases in which a Provider indicates, or the Contractor determines (on request from an Enrollee) that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor:

- (1) shall make an expedited service authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the receipt of the Service Authorization Request;
- (2) may extend the 72 hour time period by up to 14 calendar days if:
 - (i) the Enrollee requests the extension; or

(ii) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's interest.

(B) If the Contractor denies an expedited Service Authorization Request, or authorizes a requested service in an amount, duration or scope that is less than requested, the Contractor shall follow the notification requirements found in Article 7.1.3.

7.1.5 Service Authorization Decisions Not Reached Within Required Timeframes

In the event that the Contractor fails to make a service authorization decision within the required timeframes, such failure shall constitute a denial of services and shall be considered an Adverse Benefit Determination. The Contractor is required send out a Notice of Adverse Benefit Determination to the Enrollee and the Provider on the day that the timeframe expires.

7.2 Other Adverse Benefit Determinations Requiring Notice of Adverse Benefit Determination

7.2.1 Adverse Benefit Determination to Reduce, Suspend or Terminate Previously Authorized Covered Services

(A) If the Contractor seeks to reduce, suspend, or terminate previously authorized Covered Services, this constitutes an Adverse Benefit Determination.

(B) The Contractor shall notify the requesting Provider and mail a Notice of Adverse Benefit Determination to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following timeframes:

(1) at least 10 calendar days prior to the date of the Adverse Benefit Determination;
or

(2) five calendar days before the date of the Adverse Benefit Determination if the Contractor has facts indicating that the Adverse Benefit Determination should be taken because of probable Fraud by the Enrollee, and the facts have been verified, if possible, through secondary sources; or

(3) by the date of the Adverse Benefit Determination if:

(i) the Contractor has factual information confirming the death of the Enrollee;

(ii) the Contractor receives a clear, written statement from the Enrollee that:

(a) the Enrollee no longer wishes the services; or

(b) the Enrollee gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;

(iii) the Enrollee has been admitted to an institution where he is ineligible for further services;

(iv) the Enrollee's whereabouts are unknown and the post office returns mail directed to him indicating no forwarding address. In this case any discontinued services shall be reinstated if his whereabouts become known during the time he is eligible for services;

(v) the Enrollee has been accepted for Medicaid services by another local jurisdiction; or

(vi) the Enrollee's physician prescribes the change in the level of medical care.

7.2.2 Adverse Benefit Determination to Deny in Whole or in Part, Payment for a Service

(A) The Contractor shall provide a written Notice of Adverse Benefit Determination to the requesting Provider of decisions to deny payment in whole or in part but not if the denial, in whole or in part, of a payment for a service is solely because the Claim does not meet the definition of a Clean Claim.

(B) The Contractor shall also mail the Enrollee a written Notice of Adverse Benefit Determination at the time of the Adverse Benefit Determination affecting a Claim if the denial reason is that:

(1) the service was not authorized by the Contractor, and the Enrollee could be liable for payment if the Enrollee gave advance written consent that he or she would pay for the specific service; or

(2) the Enrollee requested continued services during an Appeal or State Fair Hearing and the Appeal or State Fair Hearing decision was adverse to the Enrollee.

(C) A Notice of Adverse Benefit Determination to the Enrollee is not necessary under the following circumstances:

(1) the Provider billed the Contractor in error for a non-authorized service; or

(2) the Claim included a technical error (incorrect data including procedure code, diagnosis code, Enrollee name or Medicaid identification number, date of service, etc.).

7.2.3 Adverse Benefit Determination Due to Failure to Provide Covered Services in a Timely Manner

Failure to meet the performance standards found in Article 10.4 constitutes an Adverse Benefit Determination. The Contractor shall provide a Notice of Adverse Benefit Determination to the Enrollee at the time either the Enrollee or Provider informs the Contractor that the Provider failed to meet the performance standards for offering face-to-face appointment waiting times found in Article 10.4.

7.2.4 Adverse Benefit Determination Due to Failure to Resolve Appeals or Grievances Within Prescribed Timeframes

(A) Failure of the Contractor to act within the prescribed timeframes provided for resolving and giving resolution notice for Appeals or Grievances constitutes an Adverse Benefit Determination. The Contractor shall provide a Notice of Adverse Benefit Determination to the Aggrieved Person at the time the Contractor determines the timeframe for resolving the Appeal or Grievance will not be met. If the Enrollee is not the Aggrieved Person, the Contractor shall provide the Notice of Adverse Benefit Determination to the Enrollee as well as the Aggrieved Person.

(B) If the Contractor does not resolve an Appeal within the required timeframe, the Aggrieved Person shall be considered as having completed the Contractor's Appeal process. The Contractor's failure to provide resolution of the Appeal within the required timeframe is an Adverse Benefit Determination and an Aggrieved Person is allowed to file a request for a State Fair Hearing as the Aggrieved Person has already exhausted the Contractor's internal Appeals process. The Contractor may not require the Aggrieved Person to go through the Contractor's internal Appeals process again.

(C) When issuing a Notice of Adverse Benefit Determination due to failure to resolve an Appeal within the required timeframe, the Contractor shall include in the Notice of Adverse Benefit Determination information regarding the procedures and timeframes for filing a request for a State Fair Hearing rather than information on filing an Appeal request. The Contractor shall also attach to the Notice of Adverse Benefit Determination a copy of the Medicaid State Fair Hearing request form that the Aggrieved Person can submit to request a State Fair Hearing.

7.2.5 Adverse Benefit Determination Due to Denial of an Enrollee's Request to Dispute Financial Liability

The Contractor shall provide a written Notice of Adverse Benefit Determination to an Enrollee at the time of a decision to deny an Enrollee's request to dispute financial liability, including as applicable cost sharing, copayments, premiums, deductibles, coinsurance and other Enrollee financial liabilities.

7.3 Required Content of Notice of Adverse Benefit Determination

7.3.1 General Requirements

(A) The Contractor's Notice of Adverse Benefit Determination to an Enrollee shall be in writing and meet the language and format requirements outlined in Article 3.5.

(B) All written Notices of Adverse Benefit Determination required by this Contract shall explain that:

- (1) the Adverse Benefit Determination the Contractor has taken or intends to take;
- (2) the reason for the Adverse Benefit Determination;
- (3) the right of the Enrollee to be provided upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;
- (4) the right to request an Appeal of the Adverse Benefit Determination with the Contractor;
- (5) the procedures for requesting an Appeal;
- (6) the circumstances under which expedited resolution of an Appeal is available and how to request an expedited resolution of the Appeal;
- (7) the timeframe for filing an oral or written Appeal request, which is within 60 calendar days from the date on the Contractor's Notice of Adverse Benefit Determination;
- (8) if the Adverse Benefit Determination is to reduce, suspend or terminate previously authorized services, the date the reduction, suspension or termination will become effective; and
 - (i) the Enrollee's right to request that services continue pending the outcome of an Appeal;
 - (ii) how to request that the services be continued;
 - (iii) that the Enrollee or the Enrollee's legal guardian or other authorized representative must request continuation of services;
 - (iv) the timeframe for requesting continuation of services, which is the later of the following: within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination, or by the intended effective date of the Contractor's proposed Adverse Benefit Determination; and
 - (v) that if the Appeal decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services.

7.3.2 Attachment to Notice of Adverse Benefit Determination – Written Appeal Request Form

(A) The Contractor shall develop and include as an attachment to the Notice of Adverse Benefit Determination an Appeal request form that Aggrieved Persons may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Aggrieved

Person chooses to submit a written request for an expedited Appeal, even though an oral request is all that is required. The form shall:

- (1) include a mechanism for Aggrieved Persons to request an expedited Appeal (if they choose to submit a written expedited Appeal request);
- (2) include a mechanism for the Enrollee, the Enrollee’s legal guardian or other authorized representative to request continuation of services if the Adverse Benefit Determination is to reduce, suspend, or terminate previously authorized services; and include statements that:
 - (i) continuation of services must be requested within the later of the following: within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination, or by the intended effective date of the Contractor’s proposed Adverse Benefit Determination, and if using this form to request an Appeal and continuation of services, that the form must be submitted within these timeframes; and
 - (ii) if continuation of services is requested and the Appeal decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services, to the extent that they were furnished solely because of the request for continuation of the services;
- (3) summarize the assistance available to the Aggrieved Person to complete the Appeal request form and how to request the assistance; and
- (4) include information on how the Appeal Request Form can be submitted promptly (email, fax, etc.).

(B) When the Contractor is required to inform Aggrieved Persons of their State Fair Hearing rights, the Contractor shall attach the State’s Medicaid State Fair Hearing request form.

Article 8: Grievance and Appeal System

8.1 Overall System

8.1.1 General Requirements

(A) The Contractor shall have a Grievance and Appeal System for an Aggrieved Person that includes:

- (1) a Grievance process whereby an Aggrieved Person, may file a Grievance;
- (2) an Appeals process whereby an Aggrieved Person may request an Appeal; and
- (3) procedures for an Aggrieved Person to access the State's fair hearing system.

(B) The Contractor shall incorporate all of the Grievance and Appeal System requirements found in this Contract into its written policies and procedures for Grievances and Appeals.

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

The Contractor's process for Appeals shall have only one level of review and shall:

- (1) provide that oral inquiries seeking an Appeal of an Adverse Benefit Determination are treated as an Appeal request; and
- (2) include as parties to the Appeal:
 - (i) the Enrollee and the Enrollee's representative, or
 - (ii) the legal representative of a deceased Enrollee's estate.

8.3 Standard Appeals Process

8.3.1 Authority to File

An Aggrieved Person may request a standard Appeal either orally or in writing.

8.3.2 Timing

The Aggrieved Person may request an oral or written Appeal within 60 calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination.

8.3.3 Procedures

(A) The Aggrieved Person may request an Appeal either orally or in writing.

(B) The Contractor shall give the Aggrieved Person any reasonable assistance in completing required forms for submitting a written Appeal request and taking other procedural steps related to an Appeal request. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capacity.

(C) The Contractor shall acknowledge receipt of the Appeal request either orally or in writing to the Aggrieved Person.

(D) The Contractor shall provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony, and make legal and factual arguments. The

Contractor shall inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the Appeal.

(E) The Contractor shall provide the Aggrieved Person the opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal. The Contractor shall provide this information free of charge and sufficiently in advance of the resolution timeframe.

(F) The Contractor shall include as parties to the Appeal the Enrollee and the Enrollee's representative or the legal representative of a deceased Enrollee's estate.

(G) The Contractor shall ensure that the individuals who make the decision on an Appeal are individuals who:

(1) were neither involved in any previous level of review or decision-making nor subordinate of any such individual;

(2) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:

(i) an Appeal of a denial that is based on lack of Medical Necessity;

(ii) an Appeal that involves clinical issues; and

(3) take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

8.3.4 Timeframes for Appeal Resolution and Notification

(A) The Contractor shall complete each Appeal and provide a Notice of Appeal Resolution to the affected parties as expeditiously as the Enrollee's health condition requires but no later than 30 calendar days from the day the Contractor receives the Appeal request.

(B) The Contractor may extend the timeframe for completing the Appeal and providing notice by up to 14 calendar days if:

(1) the Aggrieved Person requests the extension; or

(2) the Contractor shows (to the satisfaction of the Department upon its request) that there is need for additional information and how the delay is in the Aggrieved Person's interest.

(C) If the Contractor extends the timeframe and the extension was not requested by the Aggrieved Person, the Contractor shall:

- (1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;
- (2) give the Aggrieved Person written notice within two calendar days of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and
- (3) complete the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.3.5 Format and Content of Notice of Appeal Resolution

The Contractor shall provide a written Notice of Appeal Resolution to the affected parties in accordance with format and language requirements found in Article 3.5.3 of this Contract. The written Notice of Appeal Resolution shall include:

- (1) the results of the Appeal process and the date it was completed; and
- (2) for Appeals not resolved wholly in favor of the Aggrieved Person, the Contractor shall include the following in the written Notice of Appeal Resolution:
 - (i) the right to request a State Fair Hearing and how to do so;
 - (ii) the right of the Enrollee, the Enrollee's legal guardian or other authorized representative to request continuation of services during the State Fair Hearing if the Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services;
 - (iii) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing; and
 - (iv) a statement that if the State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services;
- (3) the timeframe for requesting a State Fair Hearing when continuation of services is not requested, and when continuation of services is requested; and
- (4) a copy of the Medicaid State Fair Hearing request form.

8.3.6 Continuation of Services During Appeals

In accordance with 42 CFR 438.420, 438.404(b)(6), and 431.230(b), the Contractor shall continue the Enrollee's disputed services during the Appeal if:

- (1) the Adverse Benefit Determination is to reduce, suspend or terminate a previously authorized course of treatment;

- (2) the services were ordered by an authorized Provider;
- (3) the period covered by the original authorization has not expired; and
- (4) the Enrollee or the Enrollee's legal guardian or other authorized representative files a request for continuation of disputed services, and files timely, which means filing on or before the later of the following:
 - (i) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or
 - (ii) by the intended effective date of the Contractor's proposed Adverse Benefit Determination.

8.3.7 Duration of Continued Disputed Services and Enrollee Responsibility

(A) If the Contractor continues the Enrollee's disputed services, the Contractor shall continue the disputed services until one of the following occurs:

- (1) the Aggrieved Person withdraws the Appeal or State Fair Hearing request;
- (2) the Aggrieved Person fails to request a State Fair Hearing within 10 calendar days after the Contractor sends the notice of an adverse resolution;
- (3) the Enrollee or the Enrollee's legal guardian, or other authorized representative that is not the Provider fails to submit to the State Fair Hearing office, within 10 calendar days after the Contractor sends the notice of an adverse resolution, a written request for continuation of the disputed services during the State Fair Hearing; or
- (4) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person.

(B) If the final resolution of the Appeal or State Fair Hearing is adverse to the Enrollee, that is, the decision upholds the Contractor's Adverse Benefit Determination, the Contractor or Provider may, consistent with the State's policy on recoveries and consistent with this Contract, recover the cost of the disputed services furnished to the Enrollee while the Appeal or State Fair Hearing was pending, to the extent the services were furnished solely because of the requirements found in Article 8.3.6 of this Contract and in accordance with 42 CFR 431.230(b).

8.3.8 Reversed Appeal Decisions

(A) If the Contractor or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal or State Fair Hearing was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

(B) If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal or

State Fair Hearing was pending, the Contractor shall pay for those services in accordance with the Department's policy and regulations.

8.4 Expedited Appeals Process

8.4.1 General Requirements

The Contractor shall establish and maintain an expedited Appeal process when:

- (1) the Contractor determines, based either upon a request from an Aggrieved Person or in the Contractor's own judgment, that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function; or
- (2) a Provider indicates that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function.

8.4.2 Authority to File

The Aggrieved Person may request an expedited Appeal either orally or in writing.

8.4.3 Timing

The Aggrieved Person may request an expedited Appeal within 60 calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination.

8.4.4 Procedures

- (A) The Aggrieved Person may request an expedited Appeal either orally or in writing.
- (B) The Contractor shall ensure that punitive action is not taken against a Provider who either requests an expedited Appeal or supports an Enrollee's Appeal request.
- (C) The Contractor shall give the Aggrieved Person any reasonable assistance in requesting an expedited Appeal and taking other procedural steps. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
- (D) The Contractor shall acknowledge receipt of the request for an expedited Appeal either orally or in writing.
- (E) The Contractor shall provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the expedited Appeal.
- (F) The Contractor shall provide the Aggrieved Person the opportunity, before and during the expedited Appeal process, to examine the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the

Appeal. The Contractor shall provide this information free of charge and sufficiently in advance of the resolution timeframe.

(G) The Contractor shall ensure that the individuals who make the decision on an Appeal are individuals who:

(1) were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(2) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:

(i) an Appeal of a denial that is based on lack of Medical Necessity; or

(ii) an Appeal that involves clinical issues; and

(3) take into account all comments, documents, records, and other information submitted by the Aggrieved Person without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

8.4.5 Denial of a Request for an Expedited Appeal

If the Contractor denies a request for an expedited Appeal, the Contractor shall:

(1) complete the Appeal using the standard timeframe of no longer than 30 calendar days from the day the Contractor receives the Appeal request, with a possible 14 calendar day extension for completing the Appeal and providing Notice of Appeal Resolution to the Aggrieved Person;

(2) make reasonable effort to give the Aggrieved Person prompt oral notice of the denial; and

(3) mail written notice within two calendar days explaining the denial, specifying the standard timeframe that must be followed, and informing the affected parties that they may file a Grievance regarding the denial of an expedited Appeal.

8.4.6 Timeframes for Expedited Appeal Resolution and Notification

(A) The Contractor shall complete each expedited Appeal and provide a Notice of Appeal Resolution to affected parties as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the Contractor receives the expedited Appeal request.

(B) The Contractor may extend the timeframe for completing the Appeal and providing notice by up to 14 calendar days if:

(1) the Aggrieved Person requests the extension; or

(2) the Contractor shows (to the satisfaction of the Department, upon its request) that there is need for additional information and how the delay is in the Aggrieved Person's interest.

(C) If the Contractor extends the timeframe and the extension was not requested by the Aggrieved Person, the Contractor shall:

- (1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;
- (2) give the Aggrieved Person written notice within two calendar days of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and
- (3) complete the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.4.7 Format and Content of Notice of Expedited Appeal Resolution

(A) The Contractor shall make reasonable effort to provide oral notice of the expedited resolution in addition to providing a written Notice of Appeal Resolution.

(B) The Contractor shall provide a written Notice of Appeal Resolution to the affected parties with the format and language requirements found in Article 3.5.3 of this Contract. The written Notice of Appeal Resolution shall include:

- (1) the results of the Appeal process and the date it was completed; and
- (2) for Appeals not resolved wholly in favor of the Aggrieved Person, the Contractor shall include the following in the written Notice of Appeal Resolution:
 - (i) the right to request a State Fair Hearing and how to do so;
 - (ii) the right of the Enrollee, the Enrollee's legal guardian or other authorized representative to request continuation of services if the Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services;
- (3) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing;
- (4) a statement that if the State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services;
- (5) the timeframe for requesting a State Fair Hearing when continuation of services is not requested, and when continuation of services is requested; and
- (6) a copy of the Medicaid State Fair Hearing request form.

8.4.8 Continuation of Disputed Services During Expedited Appeals

The Contractor shall continue the Enrollee's disputed services during the expedited Appeal if:

- (1) the Adverse Benefit Determination being appealed is to reduce, suspend or terminate a previously authorized course of treatment;
- (2) the services were ordered by an authorized Provider;
- (3) the period covered by the original authorization has not expired;
- (4) the Enrollee or the Enrollee's legal guardian or other authorized representative files a request for continuation of disputed services, and files timely, which means filing the request on or before the later of the following:
 - (i) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or
 - (ii) by the intended effective date of the Contractor's proposed Adverse Benefit Determination.

8.4.9 Duration of Continued Disputed Services During Expedited Appeals and Enrollee Responsibility

(A) If the Contractor continues the Enrollee's disputed services, the Contractor shall continue the disputed services until one of the following occurs:

- (1) the Aggrieved Person withdraws the Appeal or State Fair Hearing request;
- (2) the Aggrieved Person fails to request a State Fair Hearing within 10 calendar days after the Contractor sends the notice of an adverse resolution;
- (3) the Enrollee or the Enrollee's legal guardian, or other authorized representative that is not the Provider fails to submit to the State Fair Hearing Office, within 10 calendar days after the Contractor sends the notice of an adverse resolution, a request for continuation of the disputed services during the State Fair Hearing; or
- (4) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person.

(B) If the final resolution of the Appeal or State Fair Hearing is adverse to the Enrollee, that is, the decision upholds the Contractor's Adverse Benefit Determination, the Contractor or Provider may, consistent with the Department's policy on recoveries and consistent with this Contract, recover the cost of the disputed services furnished to the Enrollee while the Appeal or State Fair Hearing was pending to the extent the services were furnished solely because of the requirements found in Article 8.4.8 of this Contract and in accordance with 42 CFR 431.230(b).

8.4.10 Reversed Expedited Appeal Decisions

(A) If the Contractor or State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the expedited Appeal or State Fair Hearing was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination.

(B) If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the expedited Appeal or State Fair Hearing was pending, the Contractor shall pay for those services in accordance with the Department's policy and regulations.

8.5 State Fair Hearings

8.5.1 General Requirements

(A) When the Aggrieved Person has exhausted the Contractor's Appeal process and a final decision has been made, the Contractor shall provide written notification to the party or parties who initiated the Appeal of the outcome and explain in clear terms a detailed reason for the denial.

(B) The Contractor shall provide notification to the Aggrieved Person that the final Appeal decision of the Contractor may be appealed to the Department and shall give to the Aggrieved Person the Department's State Fair Hearing request form. The Contractor shall inform the Aggrieved Person that:

(1) the Aggrieved Person must request a State Fair Hearing within 120 calendar days from the date of the Contractor's Notice of Appeal Resolution; or

(2) if the Enrollee chooses to continue disputed services that the Contractor seeks to reduce, suspend or terminate that:

(i) the Aggrieved Person must, within 10 calendar days after the Contractor sends the notice of an adverse resolution, request a State Fair Hearing; and

(ii) the Enrollee or the Enrollee's legal guardian or other authorized representative must, within 10 calendar days after the Contractor sends the notice of an adverse resolution, submit to the State Fair Hearing office a written request to continue the disputed services during the State Fair Hearing.

(C) As allowed by law, the parties to the State Fair Hearing include the Contractor, the Aggrieved Person, as well as the Enrollee and the Enrollee's representative who may include legal counsel, a relative, a friend or other spokesman, or the representatives of a deceased Enrollee's estate.

(D) The parties to a State Fair Hearing shall be given an opportunity to examine at a reasonable time before the date of the hearing and during the hearing, the content of the

Enrollee's case file and all documents and records to be used by the Contractor at the hearing.

(E) The parties to the State Fair Hearing shall be given the opportunity to:

- (1) bring witnesses;
- (2) establish all pertinent facts and circumstances;
- (3) present an argument without undue interference; and
- (4) question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

(F) The State Fair Hearing with the Department is a de novo hearing. If the Aggrieved Person requests a State Fair Hearing with the Department, all parties to the hearing are bound by the Department's decision until any judicial reviews are completed. Any decision made by the Department pursuant to the hearing shall be subject to appeal rights as allowed by state and federal laws.

(G) The Aggrieved Person shall be notified in writing of the State Fair Hearing decision and any appeal rights as provided by state and federal law.

(H) In accordance with 42 CFR 431.244(f):

(1) the State Fair Hearing shall take final administrative action within 90 calendar days of the earlier of:

(i) the date the Aggrieved Person filed an Appeal with the Contractor, not including the number of days the Aggrieved Person took to subsequently file for a State Fair Hearing; or

(ii) where permitted, the date the Aggrieved Person filed for direct access to a State Fair Hearing;

2) the State Fair Hearing shall take final administrative action as expeditiously as the Enrollee's health condition requires, but no later than 3 business days after the Department receives from the Contractor the case file and information for any appeal of denial of a service that, as indicated by the Contractor:

(i) meets the criteria for expedited resolution as set forth in 42 CFR 438.410(a), but was not resolved within the timeframe for expedited resolution; or

(ii) was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the Enrollee.

8.6 Grievances

8.6.1 Authority to File a Grievance

An Enrollee, the Enrollee's legal guardian or other authorized representative, or a Provider may file a Grievance with the Contractor.

8.6.2 Timing

Grievances may be filed orally or in writing at any time.

8.6.3 Procedures

(A) The Contractor shall give Enrollees any reasonable assistance in completing required forms for submitting a written Grievance and taking other procedural steps related to the Grievance. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

(B) The Contractor shall acknowledge receipt of the Grievance either orally or in writing.

(C) The Contractor shall ensure that the individuals who make the decision on a Grievance are individuals who:

- (1) were neither involved in any previous level of review or decision-making involving the Grievance nor a subordinate of any such individual;
- (2) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:
 - (i) a Grievance regarding denial of a request for an expedited resolution of an Appeal; or
 - (ii) a Grievance that involves clinical issues; and
- (3) take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Grievance.

8.6.4 Timeframes for Grievance Disposition and Notification

(A) The Contractor shall dispose of each Grievance and provide notice to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 90 calendar days from the day the Contractor receives the Grievance.

(B) For written Grievances, the Contractor shall notify the affected parties in writing of the disposition of the Grievance. For Grievances received orally, the Contractor shall notify the affected parties of the disposition either orally or in writing. The notice of Grievance disposition shall satisfy format and language requirements in 42 CFR 438.10.

(C) If the Enrollee, the Enrollee's legal guardian or other authorized representative, or a Provider files a Grievance with the Department, the Department shall apprise the individual of the right to file the Grievance with the Contractor and how to do so.

(D) If the individual prefers, the Department shall promptly notify the Contractor of the Grievance.

(E) If the Contractor receives the Grievance from the Department, the Contractor shall follow the procedures and timeframes outlined above for Grievances.

(F) If the Contractor receives the Grievance from the Department, the Contractor shall notify the affected parties and the Department, in writing, of the disposition of the Grievance.

(G) The Contractor may extend the timeframe for disposing of the Grievance and providing notice by up to 14 calendar days if:

(1) the Enrollee requests the extension; or

(2) the Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest (upon Department request).

(H) If the Contractor extends the time frame, and the extension was not requested by the Enrollee, the Contractor shall:

(1) make reasonable efforts to give the Enrollee prompt oral notice of the delay; and

(2) give the Enrollee written notice within two calendar days of the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance about the decision.

8.7 Dispute Resolution, Reporting and Documentation

8.7.1 Reporting Requirements

The Contractor shall maintain complete records of all Appeals and Grievances and submit reports summarizing Appeals and Grievances using the Department-specified report forms.

8.7.2 Document Maintenance, Appeals

The Contractor shall accurately, and in a manner accessible to the Department and available upon request to CMS, maintain all documentation relating to Appeals which includes, but is not limited to:

(1) written Notices of Adverse Benefit Determination;

(2) date the Appeal request was received;

(3) name of the Enrollee for whom the Appeal request was filed;

(4) a log of all oral Appeal requests, and oral requests for expedited Appeals including:

- (i) date of the oral requests;
 - (ii) date of acknowledgement of oral requests for expedited Appeals and method of acknowledgment (orally or in writing); and
 - (iii) date of denials of requests for expedited Appeals; and
- (5) copies of written standard Appeal requests;
- (6) copies of written notices of denial of requests for expedited Appeals;
- (7) date of acknowledgement of written standard Appeal requests and method of acknowledgment (orally or in writing);
- (8) copies of written notices when extending the timeframe for completing standard or expedited Appeals when the Contractor initiates the extension;
- (9) date of each review, or if applicable, review meeting;
- (10) the resolution, and date of resolution at each level of review, or if applicable, review meeting;
- (11) name of person conducting the Appeal;
- (12) copies of written Notice of Appeal Resolution; and
- (13) any other pertinent documentation needed to maintain a complete record of all Appeals and to demonstrate that the Appeals were conducted according to the Contract provisions governing Appeals.

8.7.3 Document Maintenance, Grievances

(A) Using its previously established verbal complaint logging and tracking system, the Contractor shall log all oral Grievances and include:

- (1) date the Grievance was received;
- (2) general description of the Grievance;
- (3) name of Enrollee for whom the Grievance was filed;
- (4) date and method of acknowledgement (orally or in writing);
- (5) name of the person taking the Grievance;
- (6) date of resolution and summary of the resolution;
- (7) date of each review, or if applicable, review meeting;
- (8) the resolution, and date of resolution at each level of review, or if applicable, review meeting;

(9) name of person resolving the Grievance;

(10) date the Enrollee was notified of the resolution and how the Enrollee was notified (either orally or in writing). If the Enrollee was notified of the disposition in writing, the Contractor shall maintain a copy of the written notification; and

(11) any other pertinent documentation needed to maintain a complete record of all Grievances and to demonstrate that the Grievances were adjudicated according to the Contract provisions governing Grievances.

(B) The Contractor shall accurately and in a manner accessible to the Department and available upon request to CMS, maintain all written Grievances and copies of the written notices of resolution to the affected parties.

Article 9: Enrollee Rights and Protections

9.1 Written Information on Enrollee Rights and Protections

9.1.1 General Requirements

(A) The Contractor shall develop and maintain written policies regarding Enrollee rights and protections.

(B) The Contractor shall comply with any applicable federal and state laws that pertain to Enrollee rights and shall ensure that its staff and Network Providers take those rights into account when furnishing services to Enrollees.

(C) The Contractor shall ensure information on Enrollee rights and protections is provided to all Enrollees by including Enrollee rights and protections in its Enrollee handbook.

(D) The Contractor shall ensure Enrollees are free to exercise their rights, and that the exercise of those rights shall not adversely affect the way the Contractor and its Network Providers treat Enrollees by including this statement in its Enrollee handbook.

9.1.2 Specific Enrollee Rights and Protections

The Contractor shall include all of the following Enrollee rights and protections in its Enrollee handbook, and in any other written patient rights statement:

- (1) the right to receive information about Contractor's PMHP;
- (2) the right to be treated with respect and with due consideration for the Enrollee's dignity and privacy;
- (3) the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
- (4) the right to participate in decisions regarding the Enrollee's health care, including the right to refuse treatment;

(5) 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 restraints and seclusion;

(6) if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, the right to request and receive a copy of the Enrollee's medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.524 and 45 CFR 164.526;

(7) the right to be furnished health care services in accordance with access and quality standards; and

(8) the right to be free to exercise all rights and that by exercising those rights, the Enrollee shall not be treated adversely by the Contractor, its Network Providers, or the Department.

9.2 Network Provider-Enrollee Communications

9.2.1 General Requirements

The Contractor shall communicate with its Providers that when acting within the lawful scope of their practice, they shall not be prohibited from advising or advocating on behalf of the Enrollee for the following:

- (1) the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- (2) any information the Enrollee needs in order to decide among all relevant treatment options;
- (3) the risks, benefits, and consequences of treatment or non-treatment; and
- (4) the Enrollee's right to participate in decisions regarding health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 General Requirements

(A) Subject to the information requirements of Article 9.3.1(A)(1) and (2) of this Contract, if the Contractor that would be otherwise required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirements in Article 9.2.1 of this Contract, is not required to do so if the Contractor objects to the service on moral or religious grounds. If the Contractor elects this option, the Contractor shall:

- (1) furnish information to the Department about the services it does not cover prior to signing this Contract or whenever it adopts the policy during the term of the Contract;

(2) furnish the information to Potential Enrollees, before and during enrollment and to Enrollees, within 90 calendar days after adopting the policy with respect to any service; and

(3) notify Enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 calendar days prior to the effective date of the policy for any particular service.

(B) The Department shall notify Enrollees on how the Enrollees may obtain Covered Services that the Contractor has objected to providing on moral or religious grounds. Such services shall also be considered when calculating the Contractor's Capitation Rate.

9.4 Advance Directives

9.4.1 General Requirements

(A) The Contractor shall maintain written policies and procedures on Advance Directives for all adults receiving medical care by or through the Contractor.

(B) The Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.

(C) The Contractor shall educate staff concerning its policies and procedures on Advance Directives.

Article 10: Contractor Assurances

10.1 General Assurances

10.1.1 Nondiscrimination

(A) The Contractor shall designate a nondiscrimination coordinator who shall:

(1) ensure the Contractor complies with federal laws and regulations regarding nondiscrimination; and

(2) take Grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.

(B) The nondiscrimination coordinator may also handle Grievances regarding the violation of other civil rights as other federal laws and regulations protect against these forms of discrimination.

(C) The Contractor shall develop and implement a written method of administration to assure that the Contractor's programs, activities, services and benefits are equally available to all persons without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.

10.1.2 Member Services Function

- (A) The Contractor shall have in place mechanisms to help Enrollees and Potential Enrollees understand the requirements and benefits of the Prepaid Mental Health Plan.
- (B) The Contractor shall operate a Member Services function during regular business hours.
- (C) As necessary, the Contractor shall provide ongoing training to ensure that the Member Services staff is conversant in the Contractor's policies and procedures as they relate to Enrollees.
- (D) At a minimum, Member Services staff shall be responsible for:
 - (1) explaining the Contractor's rules for obtaining services; and
 - (2) fielding and responding to Enrollee questions including questions regarding Grievances and Appeals.

10.1.3 Provider Services Function

- (A) The Contractor shall operate a Provider services function during regular business hours.
- (B) At a minimum, Provider services staff shall be responsible for:
 - (1) training, including ongoing training, of the Contractor's Providers on Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;
 - (2) assisting Providers to verify whether an individual is enrolled with the Contractor;
 - (3) assisting Providers with Service Authorization Requests and referral protocols;
 - (4) assisting Providers with Claims payment procedures, including training Providers on how to bill using the National Provider Identifier (NPI) number or the Department-assigned atypical provider identification number that is known to Medicaid to avoid rejection of Encounter Data; and
 - (5) fielding and responding to Provider questions on the Grievance and Appeals System.

10.1.4 Enrollee Liability

The Contractor shall not hold an Enrollee liable for:

- (1) the debts of the Contractor if it should become insolvent;
- (2) Covered Services provided to the Enrollee, for which:
 - (i) the Department does not pay the Contractor, or
 - (ii) the Department or the Contractor does not pay the individual or Provider that furnished the services under a contractual, referral or other arrangement; and

(3) the payments to Providers that furnish Covered Services under a contract or other agreement with the Contractor that are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from the Contractor.

10.2 Contractor Assurances Regarding Access

10.2.1 Documentation Requirements

(A) The Contractor shall provide the Department adequate assurances and supporting documentation that demonstrates the Contractor has the capacity to serve the expected enrollment in its Service Area with the Department's standards for access to care.

(B) The Contractor shall submit documentation to the Department, in a format specified by the Department to demonstrate that it offers an appropriate range of Covered Services that is adequate for the anticipated number of Enrollees in the Service Area, and maintains a network of Network Providers that is sufficient in number, mix and geographic distribution to meet the anticipated number of Enrollees in the Service Area.

(C) The Contractor shall submit to the Department the documentation assuring adequate capacity and services in the Department specified format no less frequently than:

(1) at the time it enters into a contract with the Department;

(2) on an annual basis; or

(3) at any time there has been a significant change (as defined by the Department) in the Contractor's operations that would affect adequate capacity and services including changes in services, benefits, geographic Service Area or payments, or enrollment of a new population in the PMHP.

10.2.2 Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers and Physical Disability

(A) The Contractor shall minimize, with a goal to eliminate, the Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities.

(B) The Contractor shall, to facilitate proper diagnosis and treatment, provide assistance to Enrollees who have communications impediments or impairments.

(C) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, telecommunication devices for the deaf (TTY/TDD), and other auxiliary aids and services to all Enrollees as needed at no cost.

(D) The Contractor shall accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990, as amended.

(E) If the Contractor's facilities are not accessible to Enrollees with physical disabilities, the Contractor shall provide Covered Services in other accessible locations.

10.2.3 Interpretive Services

(A) The Contractor shall make oral interpretive services available free of charge for all non-English languages, not just those the Department identifies as prevalent, on an as-needed basis. These requirements shall extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the Contractor and the Contractor's Network Providers and receive Covered Services.

(B) Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the patient, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality, and the patient is advised that a free interpreter is available.

(C) The Contractor shall ensure that its Network Providers have interpreter services available.

(D) The Contractor shall cover interpretive services as described in the Utah Medicaid Provider Manual, and applicable Medicaid Information Bulletin.

(E) Nothing in Article 10.2.3 shall be construed to relieve Providers of their obligations to provide interpretive services under federal law.

10.2.4 Cultural Competence Requirements

(A) The Contractor shall have methods to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Enrollees have access to Covered Services that are delivered in a manner that meet their unique needs.

(B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollees' beliefs, being sensitive to cultural diversity, and promoting attitudes and interpersonal communication styles with staff and Network Providers that respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background, and beliefs.

(D) The Contractor shall strive to ensure its Network Providers provide culturally competent services to Enrollees. Contractor efforts to ensure provision of culturally competent services shall include but are not limited to providing training to staff and Network Providers regarding attitudes, beliefs, and practices that affect access to or provision of Covered Services.

10.2.5 No Restriction on Provider's Ability to Advise and Counsel

(A) The Contractor may not restrict a health care Provider's ability to advise and counsel Enrollees about treatment options.

(B) All Providers acting within their scope of practice, shall be permitted to freely advise an Enrollee about health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

10.3 Coordination and Continuity of Care

10.3.1 General Requirements

(A) The Contractor shall implement procedures to deliver care and to coordinate Covered Services for all Enrollees. These procedures must:

(1) ensure that each Enrollee has an ongoing source of care appropriate to the Enrollee's needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity;

(2) coordinate the services the Contractor furnishes to the Enrollee:

(i) between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) with the services the Enrollee receives from any other MCO, PIHP or PAHP;

(iii) with the services the Enrollee receives through FFS when the services are carved-out services covered directly by Medicaid; and

(iv) with the services the Enrollee receives from community and social support workers.

(B) The Contractor shall make a best effort to conduct an initial screening of each Enrollee's needs within 90 calendar days of the effective date of enrollment for all new Enrollees and shall make subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful.

(C) The Contractor shall share with the Department or other MCOs, PIHPs, and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(D) The Contractor shall ensure that each Provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards.

(E) The Contractor shall ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable.

(F) The Contractor's Network Providers are not responsible for rendering Home and Community-Based Waiver Services.

10.3.2 Accountable Care Organizations

(A) When an Enrollee is also enrolled in an Accountable Care Organization (ACO), the Contractor and ACO shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical health and mental health and/or substance use disorder services.

(B) The Contractor shall educate its Network Providers regarding an effective model of coordination between mental health/substance use disorder and physical health care services. The Contractor shall require its Network Providers to coordinate the provision of mental health and/or substance use disorder services with physical health care services as appropriate.

(C) When an Enrollee is also enrolled in an ACO, the Contractor shall not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered.

10.3.3 Special Rules for Enrollees with Special Health Care Needs

(A) The Department shall identify Enrollees with Special Health Care Needs. The Contractor shall have a mechanism in place to allow Enrollees with Special Health Care Needs to directly access a specialist.

(B) The Contractor shall implement mechanisms to comprehensively assess Enrollees with Special Health Care Needs to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

(C) The Contractor shall notify the Department of any Enrollees it identifies who need LTSS services. The Contractor shall coordinate with the Department to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

10.3.4 Contractor Follow-Up After Discharge From Psychiatric Hospitals or Mental Health Residential Treatment Programs with 17 or More Beds

In accordance with Article 3 of Attachment E of this Contract, if the Contractor authorizes inpatient hospital psychiatric services in licensed and accredited psychiatric hospitals or treatment in licensed and accredited mental health residential treatment programs with 17 or more beds for Enrollees age 21 through 64, and has not arranged follow-up Covered Services prior to discharge, then in accordance with the Department's 1115 Demonstration Waiver, the Contractor shall attempt to contact Enrollees within 72 hours of discharge to arrange services. The Contractor shall use the most effective means possible, e.g., email, text or phone calls.

10.4 Performance Standards for Timely Access

10.4.1 Definitions

For purposes of Article 10.4, the following definitions apply:

Initial Contact means an initial request to the Contractor for services by an Enrollee, the Enrollee's parent, legal guardian, or other representative, agency or Provider that is made during normal business hours and includes Enrollees who are in the community, but not a hospital, at the time the contact is made. Initial Contacts may be made by telephone or in person. Contacts by an Enrollee, the Enrollee's parent, legal guardian, or other representative or agency to generally discuss mental health services or a need for a referral are not Initial Contacts. Initial Contacts are only those contacts that include discussion of an actual appointment for the first face-to-face service.

Non-Urgent Care means Covered Services provided to an Enrollee when, based on the report of the Enrollee or the Enrollee's agent during the Initial Contact, symptoms are determined to be generally less intrusive and less serious to those requiring Urgent Care.

Urgent Care means Covered Services provided to an Enrollee when the report of the Enrollee or the Enrollee's agent during the Initial Contact does not indicate dangerousness, but the Enrollee's functioning is seriously impaired and symptoms are moderate to severe.

10.4.2 Performance Standards, General Requirements

The Contractor shall adhere to the performance standards found in Article 10.4 to ensure that Enrollees have timely access to first face-to-face services. The performance standards found in Article 10.4 govern the timeframes from Initial Contact for offering first face-to-face services to Enrollees who are seeking Covered Services for the first time.

10.4.3 Initial Contacts

(A) The Contractor shall maintain an Initial Contact data system that allows for the Contractor to track and monitor adherence to performance standards for first face-to-face Covered Services when Enrollee Initial Contacts are made during the Contractor's regular business hours excluding Initial Contacts made to crisis services after hours and on weekends.

(B) When the Contractor shall provide the Covered Service directly or shall refer the Enrollee to a Provider for the Covered Service, the Contractor shall document and maintain Initial Contact data for the Enrollee regardless of initial referral source and the performance standards found in Article 10.4 apply.

(C) When an Enrollee chooses to seek Covered Services directly from a Non-Network Provider, and the Contractor authorizes the request, the Contractor is not required to document Initial Contact data, and the performance standards found in Article 10.4 do not apply.

10.4.4 Performance Standards

(A) If based on the Initial Contact it appears the Enrollee requires Emergency Services, the Contractor shall conduct a clinical screening by telephone within 30 minutes. If the Contractor determines that the Enrollee has an emergency, the Contractor shall offer

outpatient face-to-face Emergency Services within one hour of completion of the telephone clinical screening, as appropriate. If an Initial Contact requiring outpatient Emergency Services is made on a walk-in basis, the Contractor shall offer face-to-face outpatient Emergency Services within one hour.

(B) If it is determined during the Initial Contact that the Enrollee requires Urgent Care, the Contractor shall offer a face-to-face Covered Service within a five business days of Initial Contact. The Contractor shall also provide appropriate information regarding Emergency Services to the Enrollee with instructions to contact the Contractor if more immediate services are needed.

(C) If it is determined during the Initial Contact that the Enrollee requires Non-Urgent Care, the Contractor shall offer a face-to-face Covered Service within 15 business days of the Initial Contact.

10.4.5 Documentation Requirements

(A) The Contractor shall document:

- (1) the date and time of all Initial Contacts;
- (2) whether the Initial Contacts requiring Emergency Services are by telephone or on a walk-in basis:
 - (i) the date and time of 30-minute follow-up clinical screenings for emergencies; and
 - (ii) the date and time of the emergent initial face-to-face appointment offered (if applicable);
- (3) the date and time of the Urgent and Non-Urgent initial appointment offerings;
- (4) whether the Contractor is able to offer a first face-to-face service within the required timeframe and, if not, the reason; and
- (5) the status of scheduled first face-to-face appointments: if they are kept, broken, cancelled and/or rescheduled by the Enrollee, or rescinded and rescheduled by the Contractor due to Contractor limitations and the date of any rescheduled appointments.

(B) The Contractor shall send the Enrollee a Notice of Adverse Benefit Determination when the Contractor:

- (1) cannot offer the first face-to-face service within the required timeframe, and the Enrollee is not satisfied with waiting beyond the required timeframe; or
- (2) must rescind and reschedule a previously offered and scheduled appointment for the first face-to-face service, and as a result will exceed the required timeframe, and the Enrollee is not satisfied with waiting beyond the required timeframe.

(C) The Contractor shall maintain documentation of its performance and report performance when requested by the Department using the Department-specified report template.

10.5 Billing Enrollees

10.5.1 Enrollee Billing, General Requirements

(A) Except as otherwise provided for in this Contract, no Claim for payment shall be made at any time by the Contractor or its Providers to an Enrollee accepted by that Provider as an Enrollee for any Covered Service.

(B) When a Provider accepts an Enrollee as a patient he or she shall look solely to the Contractor and any Third Party coverage for reimbursement. If the Provider fails to receive payment from the Contractor, the Enrollee cannot be held responsible for these payments.

10.5.2 Circumstances in Which an Enrollee May Be Billed

(A) A Provider may bill an Enrollee for non-covered services only as outlined in this Contract.

(B) A non-covered service is a service that is not covered under this Contract, or is not authorized by the Contractor.

(C) The Department shall specify to the Contractor the extent of Covered Services and items under the Contract as well as services not covered under the Contract but provided through FFS.

(D) An Enrollee may be billed for a non-covered service when:

- (1) the Provider has an established policy for billing all patients for services not covered by a Third Party (i.e., the charge cannot be billed only to Enrollees);
- (2) the Provider has informed the Enrollee of its policy for billing patients for non-covered services;
- (3) the Provider has advised the Enrollee prior to rendering the non-covered service that the Enrollee shall be responsible for making payment; and
- (4) an agreement, in writing, is made between the Provider and the Enrollee that details the service and the amount to be paid by the Enrollee.

(E) The Provider may bill the Enrollee for disputed services continued during the Appeal process if the requirements of Article 8.4.9 (B) of this Contract and 42 CFR 431.230(b) are met.

10.5.3 Criminal Penalties

criminal penalties shall be imposed on Providers as authorized under Section 1128B(d)(1) of the Social Security Act if the Provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

10.6 EPSDT Requirements

10.6.1 General Requirements

The Contractor shall provide to EPSDT Enrollees Covered Services and all other services required under 42 USC 1396d(r), and shall have a process through which EPSDT Enrollees may request these services.

Article 11: Payments

11.1 General Payment Provisions

11.1.1 Risk Contract

This Contract is a Risk Contract.

11.1.2 Payment Methodology

The payment methodology is described in Attachment E of this Contract.

11.1.3 Contract Maximum

In no event shall the aggregate amount of payments to the Contractor exceed the Contract maximum amount. If payments to the Contractor approach or exceed the Contract amount before the renewal date of the Contract, the Department shall make a good faith effort to execute a Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

11.1.4 Payment Recoupment

(A) The Department shall recoup any payment paid to the Contractor which was paid in error. Such error may include human or mechanical error on either part of the Contractor or the Department. Errors can include, but are not limited to, lack of eligibility or computer error.

(B) If the Contractor disagrees with the Department's determination that a payment was made in error, the Contractor may request an administrative hearing within 30 calendar days of the Department's recoupment of the Overpayment.

11.1.5 Overpayments

(A) The Contractor shall have written policies and procedures that specify:

- (1) that the Contractor shall report to the Department within 60 calendar days when it or any Subcontractor has identified Capitation Payments or other payments in excess of amounts specified in the Contract;

(2) the retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse;

(3) the process, timeframes, and documentation required for reporting to the Department the recovery of all Overpayments;

(4) the process, timeframes, and documentation required for payment to the Department of recoveries of Overpayments in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

(B) The Contractor shall have and use a mechanism for Network Providers to report to the Contractor when it has received an Overpayment, to return the Overpayment to the Contractor within 60 calendar days after the date on which the Overpayment was identified, and to notify the Contractor in writing of the reason for the Overpayment.

(C) The Contractor shall submit to the Department a quarterly report of Overpayments and recoveries within the timeframes specified by the Department. The report shall be in the Department-specified format. The Contractor shall also submit the quarterly report to the Utah OIG (mpi-@utah.gov) of Fraud, Waste, or Abuse-related Overpayments.

11.1.6 Recovery and Retention of Overpayments, Generally

The Contractor may collect and retain Overpayments from Providers. If Overpayments are related to Fraud, Waste, or Abuse, then 11.1.7 and 11.1.8 of this Article apply.

11.1.7 Collection and Retention of Overpayments Related to Fraud, Waste, or Abuse

The Contractor may collect and retain Overpayments it recovers during the Recovery Period.

11.1.8 Referral to the Utah OIG of Overpayments Related to Fraud, Waste, or Abuse

(A) When the 12 months of the Recovery Period have ended and the Contractor has not recovered any Overpayments from the Provider, or has ceased collecting Overpayments from the Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(B) If the Contractor has been collecting Overpayments from the Provider during the 12 months of the Recovery Period, the Contractor may continue to recover Overpayments from the Provider after the 12 months of the Recovery Period. If at any time after the twelfth month of the Recovery Period the Contractor determines it will be unable to continue collection, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(C) If the Contractor chooses not to pursue any Overpayment recoveries from a Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Utah OIG will retain its Overpayment recoveries.

(D) If the Utah OIG identifies an unreported Overpayment, the Utah OIG will coordinate with the Contractor and may pursue collection of the Overpayment. The Utah OIG will retain its Overpayment recoveries.

(E) The Contractor shall correct Encounter Data related to Overpayments in accordance with Article 12.4.1.

11.1.9 Managed Care Activities that May Be Vacated by the Court

Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the Capitation Payment for that work should be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its Capitation Payments to the Contractor, the Contractor may keep the Capitation Payment for that work even if the payment was made after the date the program or activity lost legal authority.

11.2 Third Party Liability and Coordination of Benefits

11.2.1 Recovery of Third Party Liability, Generally

The Contractor shall make reasonable efforts to pursue the recovery of TPL for Covered Services provided to Enrollees. To assist the Contractor, the Department shall include on the Eligibility Transmissions other known Third Parties available to each Enrollee.

11.2.2 Policies and Procedures for Third Party Liability Recovery

The Contractor shall develop policies and procedures describing how it will conduct TPL recovery. Such policies and procedures shall be consistent with the requirements of 42 U.S.C. 1396(A)(25) and 42 CFR 433 Subpart D. The policies and procedures shall contain:

- (1) procedures and mechanisms to identify potentially liable Third Parties. Procedures and mechanisms shall include at a minimum, verification of any Third Party coverage at the time of service. When Enrollees obtain Covered Services from Providers not employed by the Contractor, the Contractor may delegate the Third Party verifications to Providers;
- (2) procedures and mechanisms to identify the amount owed by a Third Party;
- (3) procedures and mechanisms for recovery of Third Party payments; and
- (4) procedures and mechanisms to report to the ORS any Third Party discrepancies identified within 30 business days of receipt of the Eligibility Transmission. The Contractor's report shall include a listing of Enrollees that the Contractor has independently identified as having another Third Party, including when an Enrollee's parent has an order of duty to provide medical support. The Contractor shall report changes to ORS either by email (TPLChanges@utah.gov) or by fax (801-536-8912).

11.2.3 Cost Avoidance and Pay and Chase

(A) The Contractor shall use reasonable efforts to evaluate the probable existence of TPL. Probable existence of TPL exists where:

- (1) the Contractor or Provider has confirmed that there was Third Party coverage in effect on the Enrollee's date of service; and
- (2) the Contractor or Provider has determined that the Third Party will likely cover the service.

(B) Except as otherwise provided in Article 11.2.3 (C) of this Contract, if the Contractor has established the probable existence of TPL, the Contractor shall, if providing services directly, seek payment from the Third Party, or at the time a Provider files a Claim with the Contractor, the Contractor must reject the Claim and return it to the Provider for a determination of the amount of liability.

- (1) The establishment of TPL takes place when the Contractor receives confirmation from the Provider or a Third Party resource indicating the extent of TPL.
- (2) If the Provider or the Third Party gives reasonable evidence that the TPL was not in effect at the time of service or the service received by the Enrollee is not covered by the Third Party, the Contractor shall pay the Claim, to the extent that the service is a Covered Service.
- (3) When the amount of liability is determined, the Contractor must then pay the Claim to the extent that payment allowed under the Contractor's payment schedule exceeds the amount of the Third Party's payment.

(C) In the following situations, the Contractor must pay the full amount allowed under the Contractor's payment schedule for the Claim and seek reimbursement from any liable Third

Party to the limit of legal liability if the Third Party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency if:

(1) the Claim is for preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under 42 CFR 441, Part B), that are covered under the State Plan; or

(2) the Claim is for a service covered under the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the state IV-D agency. In this instance the Contractor shall pay the Provider if the Provider has certified to Contractor the provider has billed a Third Party, the Provider has waited 100 days from the date of the service, and has not received payment from the Third Party.

(D) If the probable existence of TPL cannot be established or Third Party benefits are not available to pay the Enrollee's medical expenses at the time the Claim is filed, the Contractor must pay the full amount allowed under the Contractor's payment schedule.

(E) If the Contractor or Provider learns of the existence of a liable Third Party after the Contractor has provided a service or after a Provider's Claim is paid, or benefits become available from a Third Party after the Contractor has provided a service or has paid a Claim, the Contractor or Provider, as applicable, must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable Third Party or benefits become available. If the Provider obtains the payment from the Third Party, the Contractor shall recoup the payment from the Provider.

(F) The Contractor shall retain any payment it receives from TPL. Unless Article 11.2.3(E) applies, the Provider shall retain any payment it receives stemming from TPL.

(G) Recovery is not required when Claim is \$100 or less or \$300 or less for cumulative Claims.

(H) Contractor shall report TPL payments in the Encounter Data and in the PMHP Financial Reports and MLR reports submitted to the Department.

11.2.4 Third Party Liability and Access to Care

(A) The Contractor shall not require an Enrollee to obtain Covered Services from a Provider solely on the basis that the Provider accepts the Enrollee's TPL.

(B) The Contractor shall pay Claims for Covered Services obtained by an Enrollee from a Provider if the Provider is not on the Enrollee's Third Party's panel.

11.3 Contractor's Payment Responsibilities

11.3.1 Covered Services Received Outside Contractor's Network but Paid by Contractor

(A) The Contractor shall not be required to pay for Covered Services when the Enrollee receives the services from sources outside the Contractor's network, not arranged for and not authorized by the Contractor except:

- (1) Emergency Services;
- (2) court-ordered services that are Covered Services defined in Attachment C;
- (3) cases where the Enrollee demonstrates that such services are Medically Necessary and were unavailable from the Contractor's Network Providers; and
- (4) Covered Services which an Enrollee has obtained from a Non-Network Provider for purposes of utilizing the Enrollee's TPL.

11.3.2 Covered Services that are Not the Contractor's Responsibility

(A) The Contractor shall not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to earthquakes or acts of war. The effective date of excluding such Covered Services shall be the date specified by the federal government or the State of Utah that a federal or state emergency exists or disaster has occurred.

(B) The Contractor shall not be required to pay for Covered Services provided by Indian Health Care Providers. Such services shall be paid by the Department.

(C) In accordance with Article 5.3.9, Enrollees may choose to seek Covered Services from an FQHC. The Contractor shall not be required to pay for Covered Services provided by FQHCs unless the Contractor agrees to pay the FQHC under a Network Provider agreement with the FQHC. Otherwise, such services shall be paid by the Department.

11.4 Enrollee Transitions Between Managed Care Entities or Fee-For-Service

11.4.1 Transitions During Inpatient Hospital Psychiatric Stays

(A) The PMHP or UMIC Plan in which a Medicaid Eligible Individual is enrolled at the time of an inpatient hospital admission is financially responsible for the entire hospital stay including all services related to the hospital stay until the Medicaid Eligible Individual is discharged, even if the Medicaid Eligible Individual becomes enrolled in a different PMHP or UMIC Plan or changes to FFS after the month of the admission to the hospital.

(B) Covered Services provided after discharge from the inpatient stay are the responsibility of the PMHP or UMIC Plan in which the Medicaid Eligible Individual is enrolled post-discharge, or are the responsibility of the Department if the Medicaid Eligible Individual changes to FFS.

(C) If a Medicaid Eligible Individual is in FFS when admitted to the hospital and becomes enrolled with the Contractor prior to discharge from the hospital, the Department is financially responsible for the entire hospital stay including all services related to the hospital

stay until the Enrollee is discharged. The Contractor is responsible for Covered Services provided to the Enrollee during the remainder of the month of discharge.

(D) If an Enrollee loses Medicaid eligibility prior to discharge from the hospital, the Contractor is financially responsible for the hospital stay only for the period of Medicaid eligibility.

(E) If an Enrollee loses Medicaid eligibility during an inpatient hospital stay and later becomes retroactively eligible for Medicaid without a break in Medicaid coverage, then the Contractor is financially responsible for the entire inpatient stay.

11.4.2 Transition of Services for Adult Expansion Population Enrollees

If this Contract covers Adult Expansion Population Enrollees, for outpatient Covered Services other than substance use disorder treatment in a licensed substance use disorder residential treatment program and mental health treatment in licensed mental health residential treatment programs, if these Enrollees were receiving outpatient Covered Services from Non-Network Providers through FFS or a UMIC Plan prior to enrollment with the Contractor, the Contractor shall reimburse the Non-Network Providers for continued outpatient Covered Services for 90 business days from the date of enrollment with the Contractor.

11.4.3 Contractor Acceptance of Prior Authorizations Issued by Another Managed Care Entity or the Department for Substance Use Disorder Treatment in Licensed Substance Use Disorder Residential Treatment Programs and Mental Health Treatment in Licensed Mental Health Residential Treatment Programs

If another PMHP, UMIC Plan, or the Department authorized substance use disorder treatment in a licensed substance use disorder residential treatment program, or mental health treatment in a licensed mental health residential treatment program, and the individual becomes enrolled with the Contractor, the Contractor becomes responsible and shall reimburse the Provider until the other PMHP's, UMIC Plan's, or the Department's authorization expires.

11.4.4 Provision of Medical Information to the Department or Other Managed Care Entities

(A) When an Enrollee is transitioned from the Contractor to FFS or from FFS to the Contractor, the Contractor and the Department, as applicable, shall submit upon request prior to the transition any critical medical information regarding the Enrollee.

(B) When an Enrollee is transitioned from the Contractor to another PMHP or UMIC Plan, the Contractor shall submit, upon request of the Enrollee's new PMHP or UMIC Plan, any critical medical information to ensure successful transition to continued Covered Services.

Article 12: Additional Recordkeeping and Reporting Requirements

12.1 Recordkeeping Requirements

12.1.1 Health Information Systems, General Requirements

(A) The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including but not limited to, utilization, Claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

(B) The Contractor shall comply with Section 6504(a) of the Affordable Care Act which requires that the Department's claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meet Section 1903(r)(1)(F) of the Social Security Act.

(C) The Contractor shall collect data on Enrollee and Provider characteristics as specified by the Department, and on all services furnished to Enrollees through an Encounter Data system or other methods as may be specified by the Department.

12.1.2 Accuracy of Data

(A) The Contractor shall ensure that the data received from Providers are accurate and complete by:

- (1) verifying the accuracy and timeliness of the reported data, including data from Network Providers the Contractor is compensating on the basis of subcapitation payments;
- (2) screening the data for completeness, logic, and consistency; and
- (3) collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

(B) The Contractor shall make all collected data available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law.

12.1.3 Medical Records

(A) The Contractor shall maintain a medical record keeping system that complies with state and federal law.

(B) The Contractor shall require its Network Providers to maintain a medical record keeping system that complies with state and federal law.

12.1.4 Document Retention Requirements for Awards

The Contractor shall comply with the record retention and record access requirements for award recipients found in 45 CFR 74.53 which requires the Contractor to maintain financial records, supporting documents, statistical records, and all other records pertaining to an award to be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annual, from the date of the submission of the quarterly or annual financial report. The three-year retention requirement does not apply:

- (1) if any litigation, Claim, financial management review or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, Claims, or audit findings involving the records have been resolved and final action apply;
- (2) to records for real property and equipment acquired with federal funds which shall be retained for 3 years after final disposition;
- (3) when records are transferred to or maintained by the HHS awarding agency, the 3-year retention is not applicable to the recipient; and
- (4) to indirect cost rate computations or proposals, cost allocation plans and any similar computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates).

12.1.5 Record Retention Requirements, General Requirements

(A) Unless otherwise specified by this Contract or by state or federal law, the Contractor shall keep all documents and reports required by this Contract for a period of 6 years. Such documents include, but are not limited to, the attestation forms required by Article 6.3.2, Contractor's policies and procedures, Contractor's Enrollee handbooks, and copies of reports required by the Department.

(B) The Contractor shall retain, and shall require its Subcontractors to retain, Enrollee Grievance and Appeal records, base data, MLR reports, and the data, information and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, 438.610 for a period of no less than 10 years.

12.2 Additional Reporting Requirements

12.2.1 Independent Financial Audit(s)

(A) The Contractor shall electronically submit its annual audited financial report to the Department within six months after the Contractor's annual fiscal period ends. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

(B) The Contractor shall notify the Department of the dates of the entrance and exit conferences with the independent CPA firm conducting annual independent financial audits with the Contractor and shall allow the Department to participate in those conferences.

12.2.2 Enrollment, Cost and Utilization Reports

(A) The Contractor shall submit enrollment, cost and utilization reports in an electronic format designated by the Department. The Contractor is not allowed to customize or change the format of a report. The Department may amend report formats at its discretion.

(B) The Contractor shall ensure that reports are completed according to the Department's instructions.

(C) The Contractor shall certify, in writing, the accuracy and completeness, to the best of its knowledge, of its reports.

(D) If the Department requires an annual SFY PMHP Financial Report, the Contractor shall submit the report after the close of the SFY and no later than January 31st of the following year.

12.2.3 Grievance and Appeal Reports

The Contractor shall complete the Grievance and Appeal reports on a quarterly basis using the Department-specified report forms and submit the reports to the Department by the specified due dates.

12.2.4 Provider Network Reports

The Contractor shall submit a report to the Department, in a format specified by the Department, to demonstrate that the Contractor offers an appropriate range of Covered Services that is adequate for the anticipated number of Enrollees in the Service Area and that the Contractor maintains a network of Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area.

12.2.5 Other Reports

The Contractor shall provide to the Department upon request the following information in a Department-specified format:

- (1) Provider Grievance and Appeal logs;
- (2) the results of any Enrollee or Provider satisfaction surveys conducted by the Contractor (when the Department does not otherwise receive the results from the Utah Division of Substance Abuse and Mental Health);
- (3) medical management committee reports and minutes;
- (4) customer service performance data as collected by the Contractor; and
- (5) other reports deemed necessary to the Department to assess areas including but not limited to access and timeliness or quality of care.

12.2.6 Program Improvement

The Parties understand and agree that the Department shall use the reports and data collected under this Contract to improve the performance of the Contractor's managed care plan.

12.3 Encounter Data

12.3.1 General Requirements

(A) In accordance with 42 CFR 438.242(c), the Contractor agrees to maintain sufficient Enrollee Encounter Data to identify the Provider who delivers Covered Services to Enrollees.

(B) The Contractor shall transmit Encounter Data to the Department using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR 162.1101 and 162.1102.

(C) The Contractor shall submit all Encounter Data to the Department in accordance with the *X12 Standards for Electronic Data Interchange, Health Care Claim: 837 Institutional and Professional Guides*, as well as the Department's *837 Companion Guides for Institutional and Professional Encounters*, as amended.

(D) The Contractor shall submit Encounter Data to the Department within 30 calendar days of the service or Claim adjudication date.

(E) If the Contractor fails to submit at least 95 percent of its Encounter Data within the timely submission standard in 12.3.1(D), the Department may require corrective action.

(F) The Contractor shall submit Encounter Data for all services rendered to Enrollees under this Contract, including:

- (1) services for which the Contractor has determined no liability exists;
- (2) services for which the Contractor did not make any payment;
- (3) services to Enrollees provided under a Capitation or special arrangement with another facility or program; and
- (4) services provided to Enrollees who also have Medicare coverage when the Contractor provides services directly.

(G) The Contractor shall submit corrections to all rejected Encounter Data within 45 calendar days of the date the Department sends notice that Encounter Data has been rejected.

(H) If the Contractor discovers that Encounter Data for services and/or costs of Excluded Providers have been included in the submitted Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter Data.

(I) The Department will edit Encounter Data in accordance with HIPAA standards and Department instructions. The Department shall reject Encounter Data that are incomplete or that include incorrect codes.

(J) The Department will notify the Contractor of the status of rejected Encounter Data by sending the Contractor a 999 Implementation Acknowledgement for Health Care Insurance or a TA1 Interchange acknowledgment regarding file acceptance. The Department shall send a 277 Health Care Claim Status Response Transaction advising the Contractor of the status of the processed Claims. The Contractor shall be responsible for reviewing the 999, TA1, and 277 transactions and taking appropriate action when necessary.

12.3.2 Non-Enrollee Encounter Data

The Contractor shall not submit Encounter Data when services performed by the Contractor were for HOME Enrollees.

12.3.3 Encounter Data Validation

(A) The Department will conduct quarterly Encounter Data validations. To perform each validation, the Department will send the Contractor an Encounter Data validation questionnaire, and an Encounter Data submission detail file comprised of all accepted Encounter Data for the specified quarter that may be used for rate setting.

(B) The Contractor shall respond to the Department's Encounter Data validation questionnaire within 14 calendar days from the date the Department sends the questionnaire and the Encounter Data submission detail file.

(C) If the Contractor fails to comply with the Encounter Data validation process, the Department may require corrective action.

12.3.4 Encounter Data for Rate Setting

The Department will use for rate setting only the Encounter Data received by the Department's deadline.

12.4 Disallowance of Claims

12.4.1 Procedures for Incorrectly Paid Claims

(A) The Contractor shall take reasonable action to collect any incorrectly paid Claim from the Provider within 12 months of the date of discovery of the incorrectly paid Claim. Incorrectly paid Claims can include but are not limited to Claims which were duplicative, overpaid, or disallowed.

(B) The Contractor shall reverse the Encounter Data for the incorrectly paid Claims within 60 calendar days of the earlier of the date of discovery of an incorrectly paid Claim or the date of the notice of the disallowance of the incorrectly paid Claim. The Contractor shall correct any Encounter Data for any incorrectly paid Claim regardless of whether the Contractor is successful in collecting the payment from the Provider.

(C) The Contractor shall make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

- (1) the Provider has submitted a Claim for the date of service within 12 months of the date of service;
- (2) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had TPL that should have paid on the Claim;
- (3) the Provider can show, through EOBs or other sufficient evidence, that the TPL was either not in effect or will not cover the billed service; and
- (4) absent the coordination of benefits issues or the timely filing issues, the Claim is otherwise payable.

12.5 Medical Loss Ratio

12.5.1 General Requirements

(A) The Contractor shall calculate and report to the Department an MLR for each SFY, consistent with the MLR standards described in Article 12.5.

(B) The Contractor shall create a separate MLR data report for the Legacy Medicaid Population eligibility groups, and for the Adult Expansion eligibility groups if enrolled with the Contractor, and for any other groups specified by the Department.

12.5.2 Medical Loss Ratio, Calculations

(A) The MLR calculation in an MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

(B) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(C) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(D) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(E) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(F) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of Claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

12.5.3 Medical Loss Ratio, Credibility Adjustment

- (A) The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.
- (B) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department.
- (C) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.
- (D) If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

12.5.4 Medical Loss Ratio, Reporting

- (A) The Contractor shall submit an MLR report to the Department that includes for each MLR reporting year: total incurred Claims, expenditures on quality improving activities, expenditures related to fraud prevention activities as defined in 42 CFR 438.8 (e)(4), non-Claims costs, Premium revenue, taxes, licensing fees, regulatory fees, methodology(ies) for allocation of expenditures, any credibility adjustment applied, the calculated MLR, any remittance owed to the Department (if applicable), a comparison of the information reported with the audited financial report, a description of the aggregation method used to calculate total incurred Claims, and the number of member months.
- (B) The Contractor shall submit the MLR report in a Department-specified format. The Contractor's MLR report shall be submitted after the close of the SFY and no later than January 31st of the following year unless the Department directs otherwise.
- (C) The Contractor shall require any third party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 calendar days of the end of the MLR reporting year or within 30 calendar days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.
- (D) In any instance where the Department makes a retroactive change to the Capitation Payments for an MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and submit a new MLR report meeting the applicable requirements.
- (E) The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

12.6 Data Submission and Certification

12.6.1 Data Submission

(A) The Contractor shall submit the following data to the Department that are subject to the certification requirements found in 12.6.2:

- (1) Encounter Data in the form and manner described in 42 CFR 438.818 and this Contract;
- (2) data on the basis of which the Department certifies the actuarial soundness of Capitation Rates to the Contractor under 42 CFR 438.4, including base data described in 42 CFR 438.5(c) that is generated by the Contractor;
- (3) data on the basis of which the Department determines the compliance of the Contractor with the MLR requirement described in this Contract and 42 CFR 438.8;
- (4) data on the basis of which the Department determines that the Contractor has made adequate provision against the risk of insolvency as required under this Contract and 42 CFR 438.116;
- (5) documentation described in 42 CFR 438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR 438.206;
- (6) information on ownership and control described in this Contract, 42 CFR 455.104 and 42 CFR 438.230; and
- (7) the annual report of Overpayment recoveries as required by 42 CFR 438.608(d)(3).

(B) The Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's obligations under 42 CFR Part 438 as required by the Department or the Secretary of Health and Human Services.

12.6.2 Data Certification

(A) The individual who submits data, documentation or information described in Article 12.6.1 to the Department, shall provide a certification, concurrently with the submission, which attests, based on the individual's best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.

(B) The data, documentation, or information required by 12.6.1 shall be certified by:

- (1) the Contractor's Chief Executive Officer (CEO);
- (2) the Contractor's Chief Financial Officer (CFO);
- (3) a Managing Employee with authority to make the certification; or

(4) an individual who reports directly to the CEO, CFO or Managing Employee with delegated authority to sign for the CEO, CFO or Managing Employee so that the CEO, CFO or Managing Employee is ultimately responsible for the certification.

Article: 13 Compliance and Monitoring

13.1 Audits

13.1.1 Inspection and Audit of Financial Records

(A) The Department and the federal government may inspect and audit any books and/or records of the Contractor or its Network Providers that pertain to:

- (1) the ability of the Contractor to bear the risk of potential financial losses, or
- (2) services performed or determinations of amounts payable under the Contract, or
- (3) any other audit allowed by State or federal law.

(B) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law any of the Contractor's records that may reasonably be requested to conduct the audit.

(C) The Contractor shall, in accordance with 45 CFR 74.48 (and except for contracts less than the simplified acquisition threshold), allow the federal Health and Human Services (HHS) awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

13.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other Enrollee data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the Utah OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

13.1.3 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, Fraud-related data, Abuse-related data, patient outcome data, and cost utilization data, which shall include patient profiles, exception reports, etc.

(B) The Contractor shall provide all data required by the Department, the federal government, independent quality review examiners, and other Utah state agencies allowed to conduct such audits.

13.2 Utah Office of the Inspector General

13.2.1 General Requirements

(A) The Contractor shall cooperate with the Utah OIG in any performance or financial audit Medicaid funds received by the Contractor as allowed by Utah Code Ann. 63A-13-202(2).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. 63A-13-301.

(C) The Contractor and its employees shall cooperate with the Utah OIG with respect to an audit or investigation as required by Utah Code Ann. 63A-13-302, 303.

(D) In accordance with Utah Code Ann. 63A-13-304, the Contractor and its employees shall not interfere with a Utah OIG audit or investigation.

(E) The Contractor shall comply with all subpoenas from the Utah OIG that are properly issued pursuant to Utah Code Ann. 63A-13-401.

(F) The Contractor shall allow the Utah OIG to conduct announced or unannounced site visits in accordance with 42 CFR 455.432.

Article 14: Corrective Action and Sanctions

14.1 Corrective Action Plans

14.1.1 General Requirements

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department may impose a corrective action plan to cure the Contractor's non-compliance.

(B) At the Department's discretion, the corrective action plan may be developed by the Department or the Contractor.

14.1.2 Department-Issued Corrective Action Plan

- (A) The Department may develop a corrective action plan which the Department shall provide to the Contractor, in writing.
- (B) The Contractor agrees to comply with the terms of a Department-issued corrective action plan and to complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan.
- (C) If the Contractor disagrees with the Department's corrective action plan, the Contractor may file a request for an administrative hearing within 30 calendar days of receipt of the Department's corrective action plan.

14.1.3 Contractor-Generated Corrective Action Plans

- (A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.
- (B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.
- (C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 calendar days of receipt. In the event that the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised. The corrective action plan submitted by the Contractor shall be deemed approved by the Department if the Department fails to respond to the Contractor within 20 calendar days of receipt of the Contractor's corrective action plan.
- (D) The Contractor agrees to comply with the terms of a Department approved corrective action plan and to complete all required actions within the required timeframes.

14.1.4 Notice of Non-Compliance

- (A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and timeframe in which the Contractor's non-compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 calendar days to cure its non-compliance. However, the Department may shorten the 30 calendar day time period in the event that a delay would endanger an Enrollee's health or the timeframe must be shortened in order for the Department and the Contractor to meet federal guidelines.

(B) If the Contractor fails to cure the non-compliance as ordered by the Department and within the timeframes designated by the Department, the Department may, at its discretion, impose any or all of the following sanctions:

- (1) suspension of the Contractor's Capitation Payment;
- (2) assessment of civil monetary penalties; and/or
- (3) imposition of any other sanction allowed by federal and state law.

(C) The Department's imposition of any of the sanctions described in 14.1.4(B) is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in 14.1.4 (B) in no way limits additional remedies, at law or at equity, available to the Department due to the Contractor's breach of this Contract.

14.2 Capitation Payment Suspension

14.2.1 General Requirements

(A) The Department may suspend Contractor's Capitation Payments in the event that the Contractor fails to comply with any provision of this Contract.

(B) The Department may suspend the Contractor's Capitation Payments for any failure to submit or comply with a corrective action plan within the timeframes required by the Department.

(C) The Department may withhold Capitation Payments until the Department receives the State Match payment from the Local Mental Health/Substance Abuse Authority.

14.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 calendar days.

(B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments, the Contractor may request an administrative hearing within 30 calendar days of receipt of the Department's notice of intent to suspend the Capitation Payments. The Department may continue to withhold Capitation Payments through the duration of the administrative hearing, unless ordered by the hearing officer to release the Capitation Payments.

Article 15: Termination of the Contract

15.1 Without Cause Termination

15.1.1 Termination Without Cause

(A) The Contractor may terminate this Contract without cause by giving the Department written notice of termination at least 60 calendar days prior to the termination date. The termination notice must be on the first business day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 calendar days written notice.

15.1.2 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services and related administrative functions required by this Contract until midnight of the last calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or 30 calendar days following termination, whichever occurs first.

(B) Upon any termination of this Contract the Contractor shall promptly supply to the Department any information it requests regarding paid and unpaid Claims.

(C) If the Contractor, one of its Network Providers, or other Subcontractor becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor, the Network Provider, or the Subcontractor.

15.2 Termination of Contract with Cause

15.2.1 General Requirements

In accordance with the provisions set forth in Attachment A of this Contract, either party may terminate this Contract with cause.

15.2.2 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

15.3 Close Out Provisions and Transition Plan

15.3.1 Close Out Provisions

(A) Notwithstanding any provision found in Attachment A, in the event of termination of this Contract, the Contractor shall complete any and all duties required by this Contract.

(B) In the event of termination of this Contract, the Contractor shall work with the Department to create a transition plan that addresses its administrative duties and the transition of care for Enrollees. The Contractor's transition plan shall include but not be limited to:

- (1) providing written notification of the Contractor's termination to all Enrollees at least 60 days prior to the termination date of the Contract unless otherwise directed by the Department;
- (2) processing and paying any Claims generated during the lifetime of this Contract including completing Appeals by both Providers and/or Enrollees and any monetary reconciliations;
- (3) providing the Department with complete and accurate Encounter Data for all Encounters generated during the lifetime of this Contract;
- (4) providing the Department with reports as required by this Contract and any other ad-hoc reports required by the Department;
- (5) complying with any audit requests; and
- (6) orderly and reasonable transfer of care for Enrollees.

(C) With the exception of retroactive Capitation Payments, the Department shall cease enrollment of Medicaid Eligible Individuals and Capitation Payments for dates following the termination of this Contract.

(D) The Contractor shall not accept any payments from the Department after the termination of this Contract, unless payment is for the time period covered under this Contract. If the Contractor determines the Department has made a payment in error, the Contractor shall notify the Department in accordance with Article 11.1.5 (A).

(E) The Department may withhold any payments due under this Contract until the Department receives from the Contractor any written and properly executed documents as required by written instructions from the Department.

(F) Failure of the Contractor to comply with the provisions found in Article 15.3 shall be deemed a breach of Contract and the Department may exercise any remedy available under this Contract or by operation of law. The Department shall give the Contractor notice of any activities not completed after termination and shall give the Contractor an opportunity to cure any breaches prior to declaring a breach of the Contract.

Article 16: Miscellaneous Provisions

16.1 Additional Provisions

16.1.1 Integration

This Contract and all attachments hereto, contain the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.

16.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

16.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all federal and state laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of federal and state law.

16.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

16.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

16.1.6 Continuation of Services During Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly Capitation Payments to the Contractor.

16.1.7 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's 1915(b) Prepaid Mental Health Plan Waiver, the Department's 1115 Demonstration Waiver, and the Department's policies and procedures in provider manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its Network Providers comply with the policies and procedures in effect at the time Covered Services are rendered.

(B) The Contractor shall comply with all appropriate and applicable state and federal rules and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

16.1.8 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor, nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

16.1.9 CMS Approval of Contract

The Contractor understands and agrees that this Contract is subject to approval by CMS. The Contractor agrees to execute any amendment necessary to make this Contract compliant with any CMS requirements. The Contractor shall be responsible for repayment of any disallowances of FFP in the event the Contractor refuses to execute a contract amendment to bring the Contract into compliance with any CMS requirements.

16.1.10 Solvency Standards

Unless exempt under 42 CFR 438.116(b)(2), the Contractor shall meet the solvency standards required by 42 CFR 438.116(b)(1).

16.2 Data Security Provisions

16.2.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

16.2.2 Network Security

(A) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall at all times maintain network security that at minimum, includes network firewall provisioning, intrusion detection and regular third party penetration testing.

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to:

- (1) those standards which the State of Utah applies to its own network as found at dts.utah.gov/policies;
- (2) current standards set forth and maintained by the National Institute of Standards and Technology; or
- (3) any industry-accepted standards comparable to those described in 16.2.2(B)(1) or (2) of this Article.

16.2.3 Data Security

(A) The Contractor shall protect and maintain the security of Confidential Data with protection that conforms to:

- (1) standards that are at least as good as or better than that maintained by the State of Utah found at dts.utah.gov/policies;
- (2) current standards set forth and maintained by the National Institute of Standards and Technology; or
- (3) any industry accepted standards comparable to those described in 16.2.3(A)(1) or (2).

(B) The Contractor shall develop and use appropriate administrative, technical and physical security measures to preserve the confidentiality and integrity of all electronically maintained or transmitted Confidential Data. These security measures include, but are not limited to, maintaining up-to-date anti-virus software, maintaining systems with current security updates, and controlled access to the physical location of the hardware itself.

16.2.4 Data Transmission

The Contractor shall ensure that any transmission or exchange of Confidential Data from the Contractor to the Department shall take place via secure means, such as HTTPS or SFTP.

16.2.5 Data Storage

(A) The Contractor shall ensure that any Confidential Data will be stored, processed, and maintained solely on designated target servers and that no Confidential Data at any time will be processed on or transferred to any unencrypted portable or laptop computing device or any unencrypted portable storage medium.

(B) The Contractor shall ensure that any Confidential Data that is stored, processed, or maintained on a laptop, portable computing device, cell phone, or portable storage device shall be encrypted using no less than 128 bit key.

16.2.6 Data Re-Use

The Contractor shall ensure that any and all Confidential Data exchanged shall be used expressly and solely for the purposes of fulfilling this Contract and other purposes as required or permitted by law. Confidential Data shall not be distributed, repurposed or shaped across other applications, environments, or business units of the Contractor. The Parties acknowledge and agree that Contractor may use and exchange confidential information for purposes related to managing the healthcare needs of Enrollees, including quality improvement initiatives, health care operations, utilization management, and other Enrollee health management purposes.

16.2.7 Notification of Confidential Data Breach

The Contractor shall notify the Department when any Contractor system that may access, process, or store Confidential Data is subject to unintended access or disclosure. The Contractor shall notify the Department of such unintended access or disclosure within 48 hours of discovery of such access or disclosure.

16.2.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the duty of confidentiality found in Article 16.2.1 and the Confidential Data requirements found in Articles 16.2.2 through 16.2.7 to all Subcontractors used by the Contractor.

16.2.9 Access to State of Utah Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to any database maintained by the Department or by the State of Utah to whom the Department has given access.

(B) The Contractor shall notify the Department within two business days when an employee or Subcontractor who has access to a database maintained by the Department or the State of Utah no longer requires access to the database.

(C) On a quarterly basis the Contractor shall provide to the Department a log of all employees who have access to a Department or State of Utah-maintained database, and in submitting that log to the Department, shall certify that the job duties of each employee named in the log require that employee have access to a Department or State of Utah-maintained database.

16.3 Health Information Technology Standards

The Contractor shall comply with the applicable requirements for health information technology standards as described in 45 CFR 170 Subpart B, and the Interoperability Standards Advisory (ISA), by federally required deadlines.

Attachment C – Covered Services

Article 1: Covered Services, Limitations, and Exclusions

1.1 Covered Services

1.1.1 Covered Services, General Requirements

- (A) The Contractor shall provide services listed under this Article 1.1 as Covered Services.
- (B) The Parties agree that the State Plan, the Department’s 1915(b) Waiver, the Department’s 1115 Demonstration Waiver, and the Department’s provider manuals, Medicaid Information Bulletins, and Coverage and Reimbursement Look-up Tool, are the official publications of the specific services and codes Medicaid covers. In the event of a conflict among these publications, the Department retains the right to determine whether the services and codes are covered under this Contract.
- (C) The Department shall have the right to interpret the publications specified in 1.1.1 (B) above.
- (D) The Contractor shall administer Covered Services in accordance with the Department’s Medicaid provider manuals. Medicaid provider manuals provide detailed information regarding Covered Services and are available to the Contractor on the Department’s website.
- (E) The Contractor agrees that Covered Services can only be limited through utilization criteria based on Medical Necessity.
- (F) The Contractor shall ensure that Covered Services are Medically Necessary, and are of a quality that meets professionally recognized standards of health care, and shall be substantiated by records that include evidence of Medical Necessity and quality. Those records will be made available to the Department upon request.

1.1.2 Inpatient Hospital Psychiatric Services

(A) Inpatient hospital psychiatric services are services performed on an inpatient basis under the direction of a physician for a psychiatric condition manifesting itself with a sudden onset. At the time of the inpatient admission, the psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or the public safety or one that has resulted in marked psychosocial dysfunction or grave mental disability of the patient. Inpatient hospital psychiatric services must involve active psychiatric treatment which is reasonably expected to improve the patient's psychiatric condition or prevent further regression. Active psychiatric treatment is the implementation of a professionally developed individual plan of care which sets forth treatment objectives and therapies enabling the patient to be discharged or treated in a less restrictive environment.

(B) The Contractor shall pay for inpatient hospital psychiatric services regardless of where the service was delivered in the acute inpatient hospital.

(C) The Contractor shall be responsible for inpatient hospital psychiatric services for Enrollees regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder/intellectual disability, an organic disorder or a substance use disorder.

(D) History and physical examinations and physician rounds conducted during an inpatient psychiatric admission are Covered Services.

(E) If the Contractor admits or authorizes an Enrollee for inpatient hospital psychiatric services, the Contractor is responsible for payment of all services related to the inpatient admission, including but not limited to related physician services, diagnostic tests, pharmacy, etc., regardless of whether the services are Covered Services.

1.1.3 Outpatient Mental Health and Substance Use Disorder Services

(A) The following services are Covered Services under this Contract:

- (1) Psychiatric diagnostic evaluation;
- (2) Mental health assessment by a non-mental health therapist;
- (3) Psychological testing;
- (4) Individual psychotherapy;

- (5) Group psychotherapy;
- (6) Family psychotherapy with patient present;
- (7) Family psychotherapy without patient present;
- (8) Psychotherapy for crisis;
- (9) Evaluation and management services (pharmacologic management);
- (10) Psychotherapy when performed with an evaluation and management service;
- (11) Individual therapeutic behavioral services;
- (12) Group therapeutic behavioral services;
- (13) Individual skills training and development;
- (14) Psychosocial rehabilitative services;
- (15) Peer support services;
- (16) Assertive Community Treatment (ACT) if the Contractor provides Covered Services through an ACT team (bundled service);
- (17) Mobile Crisis Outreach Team (MCOT) if the Contractor provides Covered Services through an MCOT (bundled service);
- (18) Substance use disorder residential treatment (bundled service);
- (19) Mental health residential treatment (bundled service for Enrollees 21 years of age or older);
- (20) Clinically managed residential withdrawal management (social detoxification), ASAM Level 3.2 (bundled service);
- (21) Targeted case management;
- (22) Electroconvulsive therapy (ECT), including any accompanying anesthesia and other related charges;

(23) General medical consultations, neurological examinations, and neuropsychological testing, that are Medically Necessary for diagnosing a mental health or substance use disorder; and

(24) Psychiatric services rendered by a psychiatrist in the emergency room to assess a mental health or substance use disorder.

(B) The Contractor is responsible for the payment of outpatient Covered Services regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder/intellectual disability, or an organic disorder.

1.1.4 Behavioral Health Evaluations Ordered by Courts or the Department of Human Services

Evaluations requested by a court or the Utah Department of Human Services to determine if a child or parent Enrollee has a diagnosis of a mental health or substance use disorder and to recommend a course of treatment are Covered Services, except for Enrollees who are K Children.

1.1.5 1915(b)(3) Services, General Requirements

(A) Services designated as 1915(b)(3) services are Covered Services for Traditional Enrollees with Capitation Payments for inpatient and outpatient Covered Services.

(B) In accordance with the 1115 Demonstration Waiver amendment to allow additional services (which are the same services as 1915(b)(3) services authorized under the Prepaid Mental Health Plan Waiver), additional services are Covered Services for:

(1) Non-Traditional Enrollees; and

(2) Medicaid Expansion Population Enrollees if they are enrolled with the Contractor.

(C) The following services are 1915(b)(3) services:

(1) Psychoeducational services;

(2) Personal services;

(3) Respite care; and

(4) Supportive living.

1.1.6 Coverage of Services for K Children

(A) The Contractor shall be responsible for payment of inpatient hospital psychiatric services for K Children.

(B) Outpatient Covered Services for K Children are carved out of this Contract.

1.1.7 Enrollees in Nursing Facilities or Receiving Home and Community-Based Waiver Services

(A) The Contractor shall provide Covered Services to Enrollees in nursing facilities, including intermediate care facilities for intellectual disabilities (ICFs/ID), and Enrollees in Home and Community-Based Services waiver programs.

(B) The Contractor shall be responsible for coordinating treatment planning and service delivery with the nursing facility, ICF/ID or waiver organization to ensure timely delivery of Covered Services to the Enrollee.

1.1.8 EPSDT Services

The Contractor shall provide mental health and substance use disorder services to EPSDT Enrollees pursuant to 42 USC 1396d(r).

1.2 Non-Emergency Transportation Services

(A) At the Contractor's discretion, the Contractor may directly provide for Traditional Enrollees non-emergency transportation to Covered Services provided in an outpatient setting. When the Contractor directly provides non-emergency transportation, it is also a Covered Service under this Contract.

(B) The Contractor is not responsible for non-emergency transportation for:

(1) Traditional Enrollees who are using the Department's non-emergency medical transportation provider for transportation to Covered Services in an outpatient setting;

(2) Traditional Enrollees seeking to access public transportation; and

(3) Non-Traditional Enrollees.

1.3 Carved-Out Services

The Contractor is not responsible to cover the following services. These services are carved out of this Contract:

- (1) Inpatient hospital services for treatment of substance use disorders, including medical detoxification;
- (2) Methadone administration (provision of the drug by a licensed opioid treatment program [OTP]);
- (3) Evaluations requested by a court or the Utah Department of Human Services, Division of Child and Family Services, solely for the purpose of determining if a parent is able to parent and should therefore be granted custody or visitation rights;
- (4) Evaluations or reevaluations requested by the Department of Workforce Services or the Department to determine disability related to Medicaid eligibility. Such services shall be paid by the Department;
- (5) Psychiatric services ordered by an Enrollee's physician while hospitalized in a non-psychiatric unit of a hospital;
- (6) Inpatient and outpatient Covered Services for the evaluation or treatment of an Enrollee's developmental disability, intellectual disability, or organic disorder;
- (7) Mental health evaluations and psychological testing performed for physical health purposes, including prior to medical procedures;
- (8) Emergency medical transportation to inpatient hospital psychiatric services; and
- (9) Pharmacy, except when Article 1.1.2 (E) applies.

Article 2: Cost Sharing

(A) The Contractor shall only charge Enrollees co-payments consistent with the Department's cost sharing rules and policies.

(B) The Contractor shall not charge a co-payment to Indian Enrollees, pregnant women, and Enrollees who qualify for EPSDT.

Attachment D - Quality and Performance

Article 1: Quality Assessment and Performance Improvement Program

1.1 Quality Assessment and Performance Improvement Program, General Requirements

(A) Pursuant to 42 CFR §438.330, the Contractor shall have an ongoing comprehensive QAPIP for the services it furnishes to its Enrollees.

(B) The QAPIP shall include a policymaking body which oversees the QAPIP, a designated senior official responsible for administration of the program, an interdisciplinary QAPIP committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body and other functional areas of the organization.

(C) The Contractor agrees that CMS, in consultation with States and other stakeholders, may specify performance measures and topics for Performance Improvement Projects (PIPs) that would be required for the Contractor to implement.

1.2 Basic Elements of Quality Assessment and Performance Improvement Programs

At a minimum, the Contractor shall establish and maintain a Quality Assessment and Performance Improvement Program (QAPIP) that includes provisions for:

- (1) conducting Performance Improvement Projects (PIPs) in accordance with Article 1.4;
- (2) collecting and submitting performance measurement data in accordance with Article 1.5;
- (3) having in effect mechanisms to detect both underutilization and overutilization of services; and
- (4) having in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs.

1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Articles 1.1 and 1.2 above.

(B) The Contractor shall submit its written QAPIP plan to the Department by January 31st of each year.

1.4 Performance Improvement Projects

(A) The Contractor shall conduct ongoing PIPs that focus on clinical or nonclinical areas, including any PIPs required by CMS or the Department.

(B) Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and that include:

- (1) measurement of performance using objective quality indicators;
- (2) implementation of interventions to achieve improvement in the access to and the quality of care;
- (3) evaluation of effectiveness of the interventions based on the performance measures (quality indicators) specified in this Article 1.4 (B)(1); and
- (4) planning and initiation of activities for increasing or sustaining improvement.

(C) Before implementing a new PIP, the Contractor shall submit the topic to the Department for approval using a format specified by the Department.

(D) The Contractor shall report the status and results of each PIP, including those required by CMS, to the Department annually, as requested by the Department.

(E) The Contractor agrees that the Department may, at its discretion, establish a timeframe and deadline for the Contractor to complete a PIP.

1.5 Performance Measurement

(A) The Department shall identify standard performance measures, including those performance measures that may be specified by CMS.

(B) Annually, the Contractor shall:

(1) measure and report to the Department its performance using standard measures required by the Department and/or CMS;

(2) submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or

(3) perform a combination of the above activities.

(C) The Contractor shall compile and submit its performance measures report for the preceding calendar year as specified by the Department and the Department's External Quality Review Organization (EQRO).

Article 2: Quality Tracking and Monitoring

2.1 Quality Measures

(A) The Contractor agrees that selected measures, known as quality measures, and specified in Article 2.2, shall be established by the Department.

(B) The Contractor agrees that the Department may amend the quality measures found in Article 2.2. The Department, when possible, shall consult with the Contractor prior to changing the reportable quality measures and, when possible, shall negotiate with the Contractor the effective date of any new quality measures.

(C) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

2.2 Quality Measures Table

Measure Name	Responsible for Rate Calculation
NQF 0576/HEDIS-FUH: Follow-Up After Hospitalization for Mental Illness	Contractor

Article 3: External Quality Review

3.1 External Quality Review, General Requirements

(A) Pursuant to 42 CFR Part 438, Subpart E, the Department shall arrange for EQRs to annually analyze and evaluate aggregated information on the quality, timeliness, and access to Covered Services, in accordance with 42 CFR 438.358(b)(1)(i) through 438.358(b)(1)(iv).

(B) The Contractor shall maintain and make available to the EQRO all clinical and administrative records for use in EQRs.

(C) Based on the EQRO's EQR reports, the Contractor shall implement the EQRO's required corrective actions. The Contractor shall also review the EQRO's recommendations and implement them as needed or as directed by the Department.

(D) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

3.2 Contractor Staffing Requirements

(A) The Contractor shall designate an individual to serve as a liaison for the EQRs.

(B) The Contractor shall designate representatives, as needed, including but not limited to a quality improvement representative and a data representative to assist with EQRs.

3.3 Copies and On-Site Access

(A) The Contractor shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during on-site reviews.

(B) Document copying costs are the responsibility of the Contractor.

(C) Enrollee information includes, but is not limited to, medical records, administrative data, Encounter Data, and claims data, maintained by the Contractor or its Network Providers.

(D) On-Site EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate workspace, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Contractor shall assign appropriate staff to assist during onsite EQRs.

(G) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

3.4 Timeframe for Providing Information

(A) The Contractor shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by the Department.

(B) The Contractor agrees that the Department shall review requests from the Contractor for extensions of these timeframes and shall approve or disapprove the request.

Article 4: Miscellaneous Provisions

4.1 Accrediting

(A) The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.

(B) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide the Department a copy of its most recent accreditation review that includes:

(1) accreditation status, survey type, and level (as applicable);

(2) accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings; and

(3) expiration date of the accreditation.

Attachment E - Payment Methodology

Article 1: Risk Contract

1.1 Risk Contracts, Generally

- (A) This Contract is classified as a Risk Contract.
- (B) The Capitation Payments and any cost sharing from Enrollees shall be considered payment in full for all Covered Services.
- (C) The Contractor incurs loss if the cost of furnishing the Covered Services exceeds the payments under this Contract.
- (D) The Contractor may retain all Capitation Payments made by the Department, unless Article 2.4 below applies, and shall use them for Enrollees.
- (E) Pursuant to 42 CFR 438.3(e) the Contractor may provide services to Enrollees that are in addition to those covered under the State Plan, although the cost of these services cannot be included when determining rates.
- (F) The Parties understand and agree that Capitation Rates may only be made by the Department and retained by the Contractor for Medicaid-Eligible Enrollees.
- (G) The Contractor shall report to the Department within 60 calendar days when it has identified a Capitation Payment or other payments in excess of the amounts specified in this Contract.

Article 2: Payments

2.1 Payment Schedule

- (A) The Department shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the Department's 820 Enrollment Report regardless of whether the Enrollee receives a Covered Service during that month.

(B) The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, the Department reserves the right to amend the Capitation Rates to reflect the change in funding. The Department shall notify the Contractor of any change in the Capitation Rates due to a loss of funding. When possible, the Department shall make reasonable efforts to notify the Contractor at least 30 days prior to the change in Capitation Rates.

In the event of a change in Capitation Rates pursuant to a loss of funding, if the Contractor determines that the new rates are unacceptable, the Contractor may terminate this Contract after it provides 30 days written notice of intent to terminate to the Department. If the Contractor elects to terminate the Contract pursuant to this Article 2.1(B) this shall not be considered a default under the Contract.

(C) The Department shall pay Capitation Rates listed in the table below for Legacy Medicaid Population Enrollees:

Capitation Rates Effective July 1, 2021 – June 30, 2022

Rates	Description	Total Rates
A	0-5 Years	\$7.83
B	6-18 and 19-20 Independent Living	\$35.24
C	Non-Traditional Adults (19 - 64 years)	\$42.44
D	Aged (65 years and older)	\$12.72
F	Disabled, including Blind - Male (All)	\$156.64
G	Disabled, including Blind - Female (All)	\$136.70
H	Pregnant Women (All)	\$25.39
I	Medically Needy Child (0 - 18 years)	\$47.93
J	Medically Needy Adult (age 19 and older)	\$147.83
K	Foster Care (Inpatient Premiums Only)	\$49.81

(D) The Department shall pay Capitation Rates listed in the table below for Adult Expansion Population Enrollees:

Capitation Rates Effective July 1, 2021 – June 30, 2022

Rates	Description	Total Rates
N	Parent: Male (age 19-34)	\$30.28
O	Parent: Male (age 35-64)	\$18.97
S	Parent: Female (age 19-34)	\$36.02
T	Parent: Female (age 35-64)	\$27.90
U	Non-Parent: Male (age 19-34)	\$105.24
V	Non-Parent: Male (age 35-64)	\$80.14
W	Non-Parent: Female (age 19-34)	\$107.21
X	Non-Parent: Female (age 35-64)	\$76.93

2.2 Risk Corridors

(A) An MLR shall be calculated as specified in Attachment B, Article 12.5.

(B) For rate cells specified in Article 2.1. (D) above, a Risk Corridor shall be based on the following MLR threshold amounts:

(1) an MLR above 91% will result in payment from the Department to the Contractor until the MLR equals 91%;

(2) an MLR between 85% and 91% will result in no action; and

(3) an MLR less than 85% will result in the Contractor reimbursing the Department until the MLR equals 85%.

(C) The Department shall complete a cost settlement related to the MLR threshold amounts specified in (B) above within 120 days after the MLR reporting due date (as specified in Attachment B) or by a due date specified by the Department.

(D) If based on the cost settlement the Contractor is required to reimburse the Department, the Contractor shall make payment in the form of a check.

(E) If based on the cost settlement the Department is required to make a payment to the Contractor, the Department shall make payment through a gross adjustment process.

(F) After two years, the Department shall review this Contract for possible removal of Risk Corridor provisions.

2.3 Payments for Enrollees in an IMD

(A) Unless the Department's 1115 Demonstration Waiver IMD provisions in Article 3 below apply, in accordance with 42 CFR 438.6(e), the Department may make a monthly Capitation Payment to the Contractor for an Enrollee aged 21-64 receiving inpatient treatment in an IMD so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and the length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly Capitation Payment.

(B) If the Contractor has authorized a stay in a facility listed in (A), and the stay exceeds 15 days, the Contractor may be responsible to reimburse the facility; however, if the stay exceeds 15 days, the entire Encounter will not be used for Capitation Rate setting.

2.4 Payment Procedures

(A) The Department shall make payments to the Contractor through its Medicaid Management Information System (MMIS) for all Enrollees under this Contract.

(B) Unless a sanction provision found in Attachment B applies, the Department shall pay the Contractor the Capitation Rates designated in Article 2.1 of this Attachment E for all current Enrollees listed in the Department's 820 payment report.

2.5 Payment Adjustments

(A) If the Contractor believes the Department has made an error in a Capitation Payment, the Contractor shall notify the Department in writing within 60 calendar days. The Contractor shall supply supporting documentation for the Department's review. If the Department's review concludes an error occurred, the Department shall adjust the Capitation Payment.

(B) The Department shall automatically adjust Capitation Rates when an Enrollee's aid category is changed retroactively. The Department shall submit this information to the Contractor via the Eligibility Transmission.

Article 3: Contractor Payments to IMDs

(A) In accordance with the Department's 1115 Demonstration Waiver, the Contractor may use licensed and Medicare-certified psychiatric hospitals, and licensed sub-acute mental health residential treatment programs with 17 or more beds that are accredited by a nationally recognized accreditation organization for Enrollees aged 21 through 64 for up to 60 consecutive days per admission.

(B) If the Contractor has authorized a stay in a facility listed in (A), and the stay exceeds 60 days, the Contractor may be responsible to reimburse the facility; however, if the stay exceeds 60 days, the entire Encounter will not be used for Capitation Rate setting.

(C) In accordance with the Department's 1115 Demonstration Waiver, the Contractor may reimburse licensed sub-acute substance use disorder residential treatment programs that are IMDs for Enrollees age 12 or older.