

State of Utah

MANAGED CARE

QUALITY STRATEGY

DIVISION OF MEDICAID AND HEALTH FINANCING
BUREAU OF MANAGED HEALTH CARE

2021 Final

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Section I: Introduction

Program Background, Overview, Goals, and Objectives

Program Background

The Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) within the State of Utah. Utah began operating its Medicaid program in 1966 under the authority of Title XIX of the Social Security Act.

In 1990, under a waiver provided by the Health Care Financing Administration (HCFA), Utah began working with entities within the state to provide mental health services through Managed Care for Medicaid beneficiaries. DMHF began offering managed care for physical health care in 1991. Utah began operating the CHIP program in 1997.

Established in 2006, Medicaid's Healthy Outcomes Medical Excellence (HOME) program specializes in mental health and medical services for members who are dually diagnosed with a developmental disability and a mental illness.

In 2011, Senate Bill 180, Medicaid Reform, was passed during the General Legislative Session. In part, the bill required that: "The Department shall develop a proposal to amend the State Plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models." To achieve these goals, effective January 2013, DMHF implemented Accountable Care Organizations (ACO) enrolling Medicaid members into physical health managed care in Weber, Davis, Salt Lake and Utah counties.

In 2013, DMHF implemented managed care Dental Plan contracts in Weber, Davis, Salt Lake, and Utah counties to deliver full dental services for Medicaid members, and later expanded managed care dental statewide in 2019.

In 2015, mandatory enrollment in ACO physical health managed care plans expanded to include Box Elder, Cache, Wasatch, Morgan, Rich, Summit, Tooele, Washington, and Iron counties.

During the 2019 legislative session, the Utah State legislature passed Senate Bill 96 to expand Medicaid. The initial phase of the expansion waiver, called the "Bridge Plan", became effective April 1, 2019, and allowed Utah to expand Medicaid benefits to parents and adults without dependent children earning up to 100% of the federal poverty level.

Senate Bill 96 further established Medicaid's adult expansion allowing individuals up to 138% federal poverty level (FPL) to be eligible for Medicaid benefits beginning January 1, 2020. This expansion, called Adult Expansion Medicaid allowed for the development and implementation of integrated care and effective January 1, 2020, the Utah Medicaid Integrated Care (UMIC) program launched managed physical and behavioral health benefits through integrated managed care plans.

Adult Expansion Medicaid members in Davis, Salt Lake, Utah, Washington, and Weber counties are required to enroll in a Utah Medicaid Integrated Care (UMIC) plan.

Program Current State

Managed Care Plans provide medical, dental and behavioral health services to eligible Medicaid and CHIP members. Historically, a majority of Medicaid managed care service delivery has not been integrated.

DMHF operates three separate 1915(b) freedom-of-choice waivers. The names of the waivers are the Choice of Health Care Delivery Program (Choices); the Choice of Dental Care Delivery Program (Dental Choices) waiver; and the Prepaid Mental Health Plan (PMHP) waiver. Managed Care provisions are also included in Utah's 1115 demonstration waiver for the Adult Expansion group.

The Choices waiver requires Medicaid recipients living in 13 of Utah's 29 counties to enroll in a managed care plan covering physical health care. Under the Dental Choices waiver, Medicaid recipients who have dental coverage are required to enroll in a Dental Plan. Medicaid currently has two managed care Dental plans operating statewide. Those who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits and those who are pregnant, are required to enroll in a Dental Plan.

Medicaid Members, who are not eligible under Medicaid expansion, living in Utah, Salt Lake, Davis, Weber, Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, Wasatch, or Washington Counties have a choice to enroll in any of the four ACOs. Members living outside of these counties have the voluntary option to choose an ACO, if available in their county of residence, regardless of their specific Medicaid eligibility.

Under the PMHP waiver, Medicaid recipients are automatically enrolled in the PMHP that serves the recipient's county of residence for behavioral health services. Recipients in the Adult Expansion population are automatically enrolled in a UMIC plan for physical and mental health services (in the five designated counties). PMHPs are in all but one county.

Utah is home to 8 federally recognized tribes. Utah has no state recognized tribes within the states boundaries. The following are the federally recognized tribes in Utah:

- Confederated Tribes of the Goshute Reservation

- Navajo Nation; the Utah Navajo Health System, Inc.
- Northwestern Band of the Shoshone Nation
- Paiute Indian Tribe of Utah
- San Juan Southern Paiute
- Skull Valley Band of Goshute
- Ute Indian Tribe of the Uintah & Ouray Reservation
- Ute Mountain Ute, White Mesa Reservation

Salt Lake City is also the home of the Title V (Indian Health Care Improvement Act) Urban Indian Organization the UDOH confers with, the Urban Indian Center of Salt Lake. The service area for this organization encompasses 5 counties; Salt Lake, Tooele, Weber, Davis, and Utah.

American Indian and Alaska Native Medicaid members enrolled in a plan can still get physical and behavioral health services directly from an IHS, Tribal or Urban Indian Organization (I/T/U). No authorization is required from the plan for American Indian and Alaska Native Medicaid members to receive services from an I/T/U. These services are paid by the Medicaid agency.

The goals of the managed care plans are to maintain quality of care, improve health outcomes for Medicaid recipients, and to control costs. All managed care plan contracts are capitated contracts and therefore, the managed care plans assume the risk for all health care costs for their members.

Within DMHF, the Bureau of Managed Health Care (BMHC) is responsible for oversight of the delivery of quality health care services provided by all of the ACO, UMIC, PMHP, HOME, Dental and CHIP plans.

Summary of Managed Care Entity (MCEs) by Type and Operating Authority	
MCE Type	Operating Authority
Eleven Medicaid Prepaid Inpatient Health Plans (PIHP)	1915(b) Prepaid Mental Health Plans (PMHPs) waiver
Four Medicaid ACOs ¹	1915(b) Choice of Health Care Delivery (CHCD) waiver

¹ ACOs are considered MCOs for purposes of 42 CFR § 438.

One Medicaid Mental and Physical Health Plan (MCO), (HOME)	1915(a) contract authority
Four Medicaid Mental and Physical Health plans (MCO), (UMIC plans)	1115 waiver
Two CHIP MCOs	CHIPRA authority
Two Medicaid Dental PAHPs	1915(b) Choice of Dental Care Delivery Program waiver
One CHIP Dental PAHP	CHIPRA authority

Quality Improvement Council (QIC)

As part of quality management, DMHF established the Quality Improvement Council (QIC). The QIC consists of internal and external stakeholders including ACO Quality Improvement Directors. At its inception, the QIC established certain performance targets to further drive quality improvement in Medicaid and CHIP managed care. The QIC is responsible for which quality measures to track and trend using performance benchmarks and the scoring methodology adopted. These measures include some from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). HEDIS calculates performance on dimensions of care and service while CAHPS provides a report on consumer and patient experience with health care. The purpose of tracking these measures over time is to present a holistic picture of the health care quality and satisfaction provided to Utah’s Medicaid population.

Goals and Objectives

After reviewing past performance, the state identified areas for improvement including a need for better collaboration among plans, a need for more structure in the plans’ QAPIP submissions, and a focus on improving HEDIS and CAHPS rates below the national average.

Per 42 CFR § 438.340 C.2.i, all states are required to submit a managed care quality strategy to CMS. The Utah Medicaid Quality Strategy will be reviewed and submitted annually to report on the implementation and effectiveness.

DMHF’s mission is to “provide access to quality, cost-effective health care for eligible Utahns.” The Quality Strategy helps accomplish this through the following goals and objectives which align with the priorities in the National Quality Strategy³.

Goals	Quality Strategy Objectives	Populations	Actions	Performance Target
1. Better Care	1. Annual evaluation of plan performance on ACO Quality Measures and the Non-ACO Quality Measures Table	Adults, Children	Identify measures below the national average, and engage in corrective actions with the plans.	Increase the number of quality measures at or above the national average by 5%
	2. Establish baselines and an annual evaluation process for UMIC plans	Adults	Collect baselines for comparison between the integrated care model and the ACO physical health model	Compare HEDIS and CAHPS measures common to both models
	3. Improve Quality Assessment and Performance Improvement Program	Adults, Children	Provide plans with revised QAPIP instructions and reporting templates	Timely submission of all QAPIP documents by February 1st (annually); Program Description, Work Plan, and the Work Plan Evaluation
	4. Conduct semi-annual meetings with the Quality Improvement Council and Care Coordination Committee.	Adults, Children	Review of stakeholder feedback Identify goals and/or PIP topics	Improve HEDIS/CAHPS metrics currently below the national average
2. Better Health	1. Improve care coordination between the ACOs and PMHPs.	Members with Comorbidities of physical and mental health	Establish regular care coordination meetings with stakeholders. Solicit stakeholder feedback during the annual revision of the Quality Strategy.	Establish standardized processes and measurements for identified care coordination activities Make updates to managed care contracts to reflect new requirements
	2. Promote preventive care for women and children	Women, Children	Explore requiring standardized topics for inclusion in the state's QAPIP	Identify specific HEDIS measures for Performance Improvement Projects if needed

	3. Promote access to critical hospital services throughout the state.	Adults, Children	Continue directed payments to hospitals throughout the state to help ensure access and quality care	Improvement in: Plan All Cause Readmission, and Total Cost of Care - PMPM
3. Better Value	1. Require Medical Loss Ratio reporting	Medicaid, CHIP	Contractually require MLR reporting and provide MLR reporting templates	MLR of 85% or greater for expansion adult population
	2. Reduce emergency department utilization rates through better management of chronic conditions in the primary care environment	Adults, Children	Assign topic for a performance improvement project for plans below the national average for the AMB measure	Track annual trends of the AMB HEDIS measure
	3. Control health care costs while improving quality care through innovative strategies with all health plans and other stakeholders	Adults, Children	Complete a summary analysis of possible value-based payment models	Track clinical quality measures as appropriate with any implemented value-based payment method

Development and Review of Quality Strategy

Development Process

DMHF implemented previous quality strategies since it began managed care. In 1995, Utah’s Quality Assurance Monitoring Plan was developed for MCOs providing physical health services, such as primary care, inpatient and outpatient services, and pharmacy. In 2003, Utah’s Quality Assessment and Performance Improvement Plan was implemented. A separate strategy, the PMHP Quality Strategy, existed for the PMHPs providing behavioral health services. The current Quality Strategy incorporates the federal regulations issues in 2017 and addresses strategies for the ACO, PMHP, UMIC, Dental and HOME plans, for further improvement of quality within all of these managed care plans. The current quality strategy also reflects new priorities by DMHF and UDOH.

Per with 42 CFR § 438.340, the state seeks input from stakeholders for the Quality Strategy. Stakeholders include internal bureaus such as the Division of Family Health and Preparedness

(Bureaus of Maternal and Child Health, Bureau of Children with Special Health Care Needs, and Bureau of Health Promotion), and the Center for Health Data and Informatics' OHCS. Other stakeholders include the Department of Human Services, Indian Health Services (IHS), ACO compliance officers and quality improvement managers; Bureau and Division management staff, Medicaid's Medical Care Advisory Committee (MCAC), CHIP Advisory Council, the Utah Hospital Association, the Utah Medical Association and other provider and consumer associations and groups.

Public Comment

The Quality Strategy is first reviewed internally by DMHF staff and then shared with the QIC for review. Other stakeholders as mentioned above are consulted as deemed appropriate and the Quality Strategy is made available for public comment through UDOH's website (required under 42 CFR [§ 438.10\(c\)\(3\)](#)), and public stakeholder meetings.

UDOH follows the formal communication process for Consultation with tribal governments and Conferment with the Urban Indian Organization (UIO) and IHS as defined by presidential executive orders and Utah Governor EO (UDOH Policy 01.19 Intergovernmental Affairs; Utah EO_2014_005). Medicaid follows the process established within this policy to communicate with the tribes, the UIO and IHS. The UDOH Office of American Indian/Alaska Native (AI/AN) Health Affairs facilitates the initial discussions through the Utah Indian Health Advisory Board (UIHAB). If this Board requests more formal individual Consultation and/or Conferment with any tribe, the UIO, or IHS, the Office facilitates those meetings.

Timeline for Assessing the Effectiveness of the Quality Strategy

DMHF will engage in various activities to assess the effectiveness of the Quality Strategy: These include:

- Annual review and updating process with internal and external stakeholders to update and modify the Quality Strategy as needed (see Timeline for Modifying or Updating the Quality Strategy).
- Annual review of External Quality Review (EQR) technical report to assess the effectiveness of the ACO, UMIC, PMHP, Dental and HOME plans in providing accessible, quality services. The annual EQR technical report is designed per federal requirements (42 CFR § 438.364).
- EQR review of Individual Plan Reports (IPR). The IPRs provide individual plan level information for each ACO, UMIC, PMHP, Dental and HOME plan as well as information to assist in the development of any Corrective Action Plans (CAP) as needed.
- Utilization of contractually required reports in addition to IPRs to assist in evaluating ACO, UMIC, PMHP, Dental and HOME plan performance and care provided to Medicaid

and CHIP members. DMHF will review these to aid in assessing the effectiveness of the Quality Strategy.

- Review HEDIS reports and CAHPS surveys for participating plans. HEDIS reports and CAHPS surveys are completed by independent third-party vendors and help clarify the quality of care and patient satisfaction at the plan level.

Timeline for Modifying or Updating the Quality Strategy

The state Quality Strategy will be evaluated annually to determine if there has been a significant change in the subsequent year. A significant change is defined as any change to the Quality Strategy that may be foreseen to materially affect the delivery or measurement of the quality of health care services. Steps for updating the Quality Strategy include:

- Collaborating between the BMHC director and DMHF director to ensure the goals and objectives of the Quality Strategy are consistent with the goals and objectives of DMHF.
- Gathering input from DMHF staff.
- Sharing the final revised Quality Strategy with the QIC and posting it on the UDOH Medicaid website for public review and comment.
- Evaluating the Quality Strategy by the DMHF contracted EQRO.
 - o Reviewing of the EQRO feedback on the Quality Strategy, from the annual Technical Report.
- Submitting the updated Quality Strategy to CMS for approval and making it available to the public via the UDOH Medicaid website. <https://medicaid.utah.gov/managed-care/>

Going forward, an annual review of the Quality Strategy will be done following the completion of the EQRO annual report.

Section II: Assessment

Quality and Appropriateness of Care

Per 42 CFR § 438.330, DMHF has quality assessment and performance improvement strategies to ensure the delivery of quality health care by all ACO, UMIC, PMHP, Dental, and HOME plans. These strategies assist DMHF in assessing the quality and appropriateness of care furnished to all Medicaid members under ACO, UMIC, PMHP, Dental, and HOME contracts. Utah Medicaid contracts with a third-party EQRO to perform EQR activities required by regulation. Information from all state and EQR related activities is used to assess the performance of the ACO, UMIC, PMHP, and Dental plans.

42 CFR § 438.330 requires that all MCOs, PIHPs, and PAHPs have ongoing quality assessment and performance improvement programs. These programs must comply with the following requirements:

- Conduct Performance Improvement Projects (PIP)²
- Submit performance measurement data
- Detect underutilization and overutilization of services
- Assess the quality and appropriateness of care for members with special health care needs
- Maintain a health information system that collects, analyzes, integrates, and reports data

Special Health Care Needs

'Special health care needs' means members 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.

Each managed care plan is required to have policies and procedures to identify adults and children with special health care needs. ACO and UMIC plans provide information about primary care providers with training for members with special health care needs. They also ensure that there is access to appropriate specialty providers and assist with case management and coordination of care for members with special health care needs.

² Performance Improvement Projects (PIP): 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.

HOME is an example of how DMHF serves members with special health care needs. HOME is an MCO that provides physical and mental health services for members with developmental disabilities and mental illness. There is no age limit for participation in the HOME program. HOME uses a “medical HOME” model and emphasizes coordination of care between behavioral and physical health care in the same setting. The program provides primary care, referrals to specialty care, psychiatric evaluations, psychotherapy, psychosocial rehabilitation, care coordination, and other needed services.

Procedure for Identifying Health Disparities

Medicaid uses the application process to identify race, ethnicity, and primary language, which are optional fields on the application. The Utah Department of Workforce Services (DWS) processes Medicaid applications in Utah. The information from the application is entered into the DWS database which is then shared with DMHF. DMHF sends the ACO, UMIC, PMHP, Dental, and HOME plans an eligibility file with the available information regarding the primary language, race, and ethnicity of each Medicaid member.

DMHF through the Quality Improvement Committee, will continue to utilize the data gathered through the enrollment process to identify, evaluate, and reduce, to the extent practicable, health disparities. The Quality Improvement Committee is working with plans to evaluate their ability to stratify HEDIS and CAHPS measures to identify health disparities based on zip code, age, race, ethnicity, sex, primary language, and disability status.

DMHF will engage with the Office of Health Disparities and other public health entities within UDOH to collect data and coordinate efforts to address health disparities.

National Performance Measures

All ACO and UMIC plans report HEDIS and CAHPS measures to the Office of Health Care Statistics (OHCS) at UDOH. These include HEDIS and CAHPS measures. HEDIS and CAHPS results are trended over time and ACOs/UMIC plans performing below the national average may be subject to a CAP. CAPs focus on efforts that the managed care organizations will take to improve their quality and satisfaction scores.

HEDIS and CAHPS measures are posted annually by the Utah Office of Health Care Statistics at: <http://stats.health.utah.gov/about-the-data/health-plan-quality/>

The following is a full set of the HEDIS and CAHPS measures used to measure plan performance and improvement for the ACO, UMIC, and CHIP plans. The goal for each plan to maintain performance rates at or above the national average.

Metric name	Metric specifications	Baseline performance (2020)	Performance target (2021)	Program		
				ACO	CHIP	UMIC
CIS: Childhood Immunization Status: Combo 3	HEDIS	74.8%	≥ 74.8%	✓	✓	
W15: 6+ Well Visits in first 15 Months	HEDIS	62.51%	≥ 66.1%	✓	✓	
IMA: Immunization for Adolescents Combo 2	HEDIS	33.79%	≥ 37.59%	✓	✓	
W34: Well Child Visits Age 3-6	HEDIS	65.31%	≥ 74.08%	✓	✓	
URI: Appropriate Treatment for Children with Upper Respiratory Infection	HEDIS	93.85%	≥ 93.85%	✓	✓	
WCC: Child/Adolescent BMI Assessment	HEDIS	77.85%	≥ 77.85%	✓	✓	
PPC: Postpartum Care	HEDIS	74.27%	≥ 75.22%	✓		✓
PPC: Timeliness of Prenatal Care	HEDIS	85.53%	≥ 87.38%	✓		✓
BCS: Breast Cancer Screening	HEDIS	43.54%	≥ 58.35%	✓		✓
CCS: Cervical Cancer Screening	HEDIS	51.22%	≥ 60.13%	✓		✓
AAP: Access to Preventive Ambulatory Health Services	HEDIS	85.58%	≥ 85.58%	✓		✓
CDC-D: Diabetes A1c Testing	HEDIS	89.16%	≥ 89.16%	✓		✓
CDC-G: Diabetes Eye Exam	HEDIS	58.25%	≥ 58.25%	✓		✓
CBP: Controlling High Blood Pressure	HEDIS	69.72%	≥ 69.72%	✓		✓
LBP: Use of Imaging for Low Back Pain	HEDIS	74.31%	≥ 74.62%	✓		✓
AMM: Antidepressant Medication Management – Acute Phase	HEDIS	51.0%	≥ 54.94%	✓		✓
IET: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	TBD	≥ 14.45%			✓
SMC: Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder	HEDIS	TBD	≥ 77.69%			✓

Metric name	Metric specifications	Baseline performance (2020)	Performance target (2021)	Program		
				ACO	CHIP	UMIC
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder	HEDIS	TBD	≥ 81.66%			✓
SMD: Diabetes Monitoring for People with Schizophrenia or Bipolar Disorder	HEDIS	TBD	≥ 70.73%			✓
FUH: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS	7-Day: TBD	7-Day: ≥ 41.32%			✓
		30-Day: TBD	30-Day: ≥ 55.51%			
FUM: Follow-Up After Emergency Department Visit for Mental Illness	HEDIS	7-Day: TBD	7-Day: ≥ 31.77%			✓
		30-Day: TBD	30-Day: ≥ 51.45%			
Getting Needed Care (Adult)	CAHPS	NA	≥ 82.96%	✓		✓
Getting Care Quickly (Adult)	CAHPS	NA	≥ 82.35%	✓		✓
Customer Satisfaction (Adult)	CAHPS	NA	≥ 89.27%	✓		✓
How Well Doctors Communicate (Adult)	CAHPS	NA	≥ 93.16%	✓		✓
Health Care (Adult)	CAHPS	NA	≥ 76.43%	✓		✓
Health Plan (Adult)	CAHPS	NA	≥ 78.5%	✓		✓
Personal Doctor (Adult)	CAHPS	NA	≥ 83.46%	✓		✓
Specialist (Adult)	CAHPS	NA	≥ 83.93%	✓		✓
Getting Needed Care (Child)	CAHPS	83.83%	≥ 85.92%	✓	✓	✓
Getting Care Quickly (Child)	CAHPS	91.33%	≥ 91.33%	✓	✓	✓
Customer Satisfaction (Child)	CAHPS	87.6%	≥ 88.81%	✓	✓	✓
How Well Doctors Communicate (Child)	CAHPS	95.83%	≥ 95.83%	✓	✓	✓
Health Care (Child)	CAHPS	90.0%	≥ 90.0%	✓	✓	✓
Health Plan (Child)	CAHPS	85.94%	≥ 85.94%	✓	✓	✓
Personal Doctor (Child)	CAHPS	93.21%	≥ 93.21%	✓	✓	✓
Specialist (Child)	CAHPS	82.91%	≥ 87.01%	✓	✓	✓

The collection of the preventive HEDIS measures will assist DMHF in measuring the achievement of the goal to provide “Better Care.” The goals state that ACOs will perform at or above the national average on these measures to ensure that Medicaid members receive high-quality care. The other ACO quality measures will assist DMHF in determining the achievement of the goal to, “Improve the access to and quality of services provided to Medicaid members in ACOs...”

PMHPs report to Medicaid on timely access to services; including measures to assess face-to-face appointments. PMHPs currently report on the “Follow-Up After Hospitalization for Mental Illness” (FUH) measure. Medicaid and the QIC will continue to assess the need to add quality measures as needed to address PMHP quality improvement.

UMIC plans report on all adult preventive HEDIS measures addressed by the ACOs, and the behavioral health measures addressed by the PMHPs. Additionally, UMIC plans also report on integration specific measures, tying both physical health and behavioral health together. The Dental plans are required to report the “Annual Dental Visit” (ADV) HEDIS measure and CAHPS survey results. They are also required to submit service performance measures for children that have received preventive dental services, dental treatment services, and sealants on a permanent molar. CMS 416 reporting for the Dental plans includes the total number of members receiving any dental service, a dental diagnostic service, and any dental or oral health service. DMHF and QIC may develop additional performance and quality measures for the Dental plans to report.

HOME currently reports performance measures to UDOH which include readmission rates, availability of appointments, care coverage, hospital follow-up, and a performance improvement project to analyze the metabolic monitoring rates of HOME members prescribed antipsychotic drugs. DMHF and the QIC may develop additional performance and quality measures for HOME to report.

The following is a table of the Performance Measure Validation for the non-ACO Medicaid plans:

Non-ACO Quality Measures Table	
Mental Health PIHPs	FUH: Follow-Up After Hospitalization
Medical MCO (HOME)	FUH: Follow-Up After Hospitalization
Dental PAHPs	ADV: Annual Dental Visit

Performance Improvement Projects (PIPs)

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical care and services in nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using a sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

PIP validation is conducted by an EQRO with the primary objective of determining a health plan’s compliance with the requirements of 42 CFR § 438.330(d) including:

- Measurement of performance using objective quality indicators
- Implementation of systematic interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

For CY 2020, the EQRO validated 20 PIPs.

CY 2020 PIP Topics by Plan

Health Plan	PIP Topic	PIP Intervention
Health Choice	Breast Cancer Screening	Clearly and completely describe its QI processes and team used to identify and prioritize the documented barriers.
Healthy U	Well Child Visits for 3-6-year-old	Discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
Molina	Breast Cancer Screening for Women Ages 50–74	Reference the PIP Completion Instructions annually to ensure that all requirements for each completed activity have been addressed.
SelectHealth	HPV Vaccine Before 13th Birthday for Female Medicaid Members	Redetermine the baseline measurement period to allow for comparability of remeasurement data to the baseline.
HOME	Impact of clinical and educational interventions on progression of prediabetes to Type II Diabetes Mellitus	Continue to revisit the causal/barrier analysis and QI processes at least annually to reevaluate barriers and develop new interventions as needed.
Bear River	Suicide Prevention	Continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
Central	Suicide Prevention	Address all General Comments documented in the PIP Validation Tool. General Comments are

		associated with <i>Met</i> validation scores. If these comments are not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .
Davis	Suicide Prevention	Develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Four Corners	Suicide Prevention	Address all General Comments documented in the PIP Validation Tool. General Comments are associated with <i>Met</i> validation scores. If these comments are not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .
Northeastern	Suicide Prevention	Address all General Comments documented in the PIP Validation Tool. General Comments are associated with <i>Met</i> validation scores. If these comments are not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .
Salt Lake	Suicide Prevention	Address all <i>Partially Met</i> and General Comments documented in the PIP Validation Tool. General Comments are associated with <i>Met</i> validation scores. If these comments not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .
Southwest	Suicide Prevention	Develop an evaluation methodology to determine the effectiveness of the implemented intervention and report evaluation results. Intervention-specific evaluation results should guide next steps for each individual intervention.
Utah County Department of Drug and Alcohol Treatment and Prevention	Suicide Prevention	Continue to build on its momentum of improvement to ensure it continues to sustain the improvement achieved.
Valley	Suicide Prevention	Document factors that could affect the comparability of the data reported. If no such

		factors exist, Valley should document this in Step VII of the PIP Summary Form.
Wasatch	Suicide Prevention	Develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Weber	Suicide Prevention	Address all General Comments documented in the PIP Validation Tool prior to the next annual submission. General Comments are associated with <i>Met</i> validation scores. If these comments are not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .
Molina CHIP	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
SelectHealth CHIP	HPV Vaccine Prior to 13th Birthday for Female CHIP Members	Reference the PIP Completion Instructions annually to ensure that all requirements for each completed activity have been addressed.
MCNA Dental	Annual Dental Visits	Develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
Premier Dental	Improving Dental Sealant Rates in Members Ages 6-9	Address all <i>Partially Met</i> and General Comments documented in the PIP Validation Tool. General Comments are associated with <i>Met</i> validation scores. If these comments are not addressed, the evaluation element may be scored down accordingly, and the evaluation element may no longer be <i>Met</i> .

Monitoring and Compliance

42 CFR Subpart D details access, structure and operations, and measurement and improvement standards for MCOs and PIHPs. Each ACO and PMHP is responsible for compliance with all of these standards as specified in their managed care contracts.

DMHF has contractual requirements with the ACO and UMIC plans which are overseen through the following programs/methods:

- Semi-Annual Reports (Includes reports on organ transplants, obstetrical information, grievance and appeals, and corrective actions)
- Reports of Abortions, Sterilizations, and Hysterectomies
- Provider Network Reports
- Case Management Reports
- Provider Statistical and Reimbursement Reporting
- Reports on HEDIS Results
- Reports of CAHPS Results
- Reports on Performance Measures
- PIPs

Contractual requirements between DMHF and the PMHPs include that the PMHPs submit the following reports to DMHF :

- Annual Independent Financial Audits
- Annual PMHP Financial Reports
- Semi-Annual Grievance and Appeals Reports
- Performance Standards Reports
- Reports of Potential Provider-Related Fraud, Waste or Abuse
- Reports of Prohibited Affiliations with Individuals Debarred by Federal Agencies
- Reports of Excluded Providers

The Dental Plans are required to submit the following reports to DMHF:

- Semi-Annual and Annual Enrollment, Cost and Utilization Reports
- Monthly Encounter Data Reports
- Monthly Income Statements
- Semi-Annual Summaries of Complaints and Formal Grievances
- Semi-Annual Summaries of Corrective Actions on Participating Providers
- Semi-Annual Cost and Utilization Reports
- Semi-Annual Claims Data
- Semi-Annual Descriptions of Subcontractor Claims Processing Times
- Annual Dental Plan Disclosure Files

- Provider Network Reports
- Quarterly Service Performance Measures Reports,
- The Quarterly CMS 416 Report
- Annual HEDIS and CAHPS reports

DMHF's contracts with the ACO, UMIC, PMHP, Dental, and HOME plans also allow for additional audits of financial records and inspections. DMHF may request other reports as necessary to continue to assess quality improvement.

The Utah State Medical Care Advisory Committee (MCAC) serves as an advisory committee to UDOH and DMHF on health and medical care services within the Medicaid program. The committee advises and makes recommendations about the Medicaid program to UDOH as requested.

The Utah CHIP Advisory Committee also serves as an advisory committee to DMHF on health and medical care services within the CHIP program. The committee advises and makes recommendations about the CHIP program to DMHF as requested.

External Quality Review

DMHF contracts with a third-party vendor to conduct the EQR as described in 42 CFR § 438 subpart E. This EQRO has responsibility for the mandatory review that must be conducted every three years to ensure MCOs, PIHPs, and PAHPs comply with federal managed care standards related to access to care, structure and operations, and quality measurement and improvement. The EQRO produces an Individual Plan Report (IPR) for each managed care plan and based on the information from the IPRs, managed care plans develop CAP as needed.

The EQRO is responsible for two other mandatory EQR activities:

- Validation of PIPs required by the state to comply with requirements that were underway during the preceding 12 months; and
- Validation of performance measures reported to the state or performance measures calculated by the state during the preceding 12 months to comply with requirements.

DMHF reviews the EQR reports and analyses from the EQRO reviews related to their recommended corrective actions to determine if DMHF concurs. If CAPs are needed, the EQRO and DMHF review the CAPs to ensure the plans have identified appropriate corrective actions. The following is a tentative initial compliance review schedule for the managed care plans.

2021 Utah Compliance Review Schedule

Health Plan	Compliance Review Dates	Draft to UDOH	Draft to Plan	Final Report
Central Utah Counseling Center	May 24-25	June 22	July 15	August 9
Bear River Mental Health	May 24-25	June 24	July 19	August 11
Northeastern Counseling Center	May 26-27	June 24	July 19	August 11
Weber Mental Health	May 26-27	June 29	July 22	August 16
Davis Behavioral Health	June 14-15	July 13	August 5	August 30
Wasatch Behavioral Health	June 16-17	July 15	August 9	September 1
Southwest Behavioral Health	June 21-22	July 20	August 12	September 6
Four Corners Community Behavioral Health	June 23-24	July 23	August 17	September 10
Salt Lake County Division of Behavioral Health/Optum	July 12-13	August 10	September 2	September 27
Healthy U	July 12-13	August 16	September 8	October 1
Optum/Tooele	July 14-15	August 16	September 8	October 1
HOME	July 14-15	August 17	September 10	October 5
Steward Health Choice Utah	August 2-4	September 1	September 24	October 19
Molina Healthcare of Utah	August 2-4	September 2	September 27	October 21
SelectHealth	August 2-4	September 3	September 28	October 21
Premier Access	August 5-6	September 6	September 29	October 25
MCNA	August 5-6	September 8	September 30	October 25

Nonduplication of Mandatory Activities

Consistent with 42 CFR § 438.360, the state will accept and use information from a Medicare or private accreditation review of an MCO, PIHP, or PAHP to provide information for the annual EQR instead of conducting one or more of the EQR activities if the following conditions are met:

- a. The MCO, PIHP, or PAHP complies with the applicable Medicare Advantage standards established by CMS, as determined by CMS or its contractor for Medicare;

- b. The Medicare or private accreditation review standards are comparable to standards established through the EQR protocols for the EQR activities described in 42 CFR § 438.358(b)(1)(i) through (iii); and
- c. The MCO, PIHP, or PAHP provides the state all the reports, findings, and other results of the Medicare or private accreditation review activities applicable to the standards for EQR activities.

Based on a review of the available information, the state does not utilize the non-duplication option.

Section III: State Standards

DMHF 's contracts with the ACO, UMIC, PMHP, and Dental plans include the standards for access, structure and operations, and quality measurement and improvement as specified in 42 CFR § 438 Subpart D. The standards incorporated into ACO, UMIC, PMHP, and Dental plan contracts include the following Subpart D provisions:

Access

Availability of services, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

- a. All standards for ACOs related to access can be found in Article 5, Delivery Network, of the ACO contract.
 - o The contract specifically outlines directed payments to hospitals to assure access for Medicaid members. DMHF evaluates the efficacy of this intervention by tracking Plan All Cause Readmissions as well as the Total Cost of Care Population-based PMPM Index.
- b. All standards for UMIC plans related to access can be found in Article 5, Delivery Network, of the UMIC contract.
- c. All standards for PMHPs related to access can be found in Article 5, Delivery Network, of the PMHP contract.
- d. All standards for the Dental plans related to access can be found in Article 5, Delivery Network of the Dental contract.
- e. All standards for HOME related to access can be found in Article 10, Contractor Assurances and Article 7, Authorization of Services and Notices of Action, of the HOME Contract.

Transition of Care Policy

To facilitate transitions of care, the state makes its transition of care policy publicly available to enrollees and potential enrollees (<https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf>), including how to access continued services upon transitioning (42 CFR § 438.62(b)(3)). MCEs are required to allow enrollees to receive care from non-participating providers with whom an enrollee has documented, established relationships, in the case where, the enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The MCO must make a good faith effort to subcontract with the non-participating provider and if a transition is necessary, shall facilitate collaboration between the non-participating provider and the new participating provider to plan a safe, medically appropriate transition of care. This transition period is not to be less than 90 days unless agreed upon by all parties.

Structure and operations

Provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems and sub-contractual relationships and delegation.

- a. All standards for ACOs related to structure and operations can be found in Article 6, Program Integrity Requirements, and Article 8, Grievance and Appeals Systems, of the ACO contract.
- b. All standards for UMIC plans related to structure and operations can be found in Article 6, Program Integrity Requirements, and Article 8, Grievance and Appeals Systems, of the UMIC contract.
- c. All standards for PMHPs related to structure and operations can be found in Article 9, Enrollee Rights and Protections, Article 8, Grievance and Appeals Systems, and Article 6, Program Integrity Requirements, of the PMHP contract.
- d. All standards for the Dental plans related to structure and operations can be found in Article 5, Delivery Network, and Article 8, Grievance and Appeals Systems, of the Dental contract.
- e. All standards for HOME related to structure and operations can be found in Article 3, Marketing, Enrollment, Orientation, and Disenrollment, Article 4, Benefits, Article 5, Delivery Network, and Article 7, Grievance Systems, of the HOME contract.

Measurement and improvement

Practice guidelines, quality assessment, and performance improvement program and health information systems.

- a. All standards for ACOs related to measurement and improvement can be found in Article 13, Compliance and Monitoring, of the ACO contract.
- b. All standards for UMIC plans related to measurement and improvement can be found in Article 13, Compliance and Monitoring, of the UMIC contract.
- c. All standards for PMHPs related to measurement and improvement can be found in Article 1.1 Attachment D, Quality Assessment and Performance Improvement, of the PMHP contract.
- d. All standards for the Dental plans related to measurement and improvement can be found in Article 11, Measurement and Improvement Standards, of the Dental contract.
- e. All standards for HOME related to measurement and improvement standards can be found in Attachment D, Quality and Performance Measures, of the HOME contract.

Network Adequacy Standards

All health plans are required to 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 in the plan contracts.

Provider crosswalks are used to describe how to identify a variety of providers in the following categories; Primary Care Providers (PCPs), specialists, behavioral health providers, health care facilities, and dental providers. Provider categories are identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree.

In establishing a plan's availability of services, contracted plans must consider the following when applicable:

- 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 number and type (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services
- 4) The number of network providers who are not accepting new Medicaid patients
- 5) The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

Network Adequacy requirements vary by plan and are detailed in the individual plan contracts.

- a. All standards for ACOs related to Network Adequacy standards and review can be found in Article 5, Delivery Network, of the ACO contract. (Appendix C)
- b. All standards for UMIC plans related to Network Adequacy standards and review can be found in Article 5, Delivery Network, of the UMIC contract. (Appendix D)
- c. All standards for PMHPs related to Network Adequacy standards and review can be found in Article 5, Delivery Network, of the PMHP contract. (Appendix E)
- d. All standards for the Dental plans related to Network Adequacy standards and review can be found in Article 5, Delivery Network of the Dental contract. (Appendix F)
- e. All standards for HOME related to Network Adequacy standards and review can be found in Article 10, Contractor Assurances and Article 7, Authorization of Services and Notices of Action, of the HOME Contract. (Appendix G)

Section IV: Improvement and Interventions

DMHF has implemented several interventions to support the CMS triple aim framework for optimizing health system performance. The triple aim is to simultaneously improve quality of care (Better Care), health of populations (Better Health), and reducing per capita cost (Better Value).

Restriction Program

DMHF manages the Restriction Program which safeguards against inappropriate and excessive use of Medicaid services. Members meeting one or more of the following criteria may be referred to and enrolled in the Restriction Program.

- Four or more PCPs, non-affiliated, seen within the past twelve months of Medicaid eligibility and/or four or more specialists seen outside a normal range of utilization during those 12 months.
- Four or more pharmacies accessed for abuse potential medications within the past twelve months of Medicaid eligibility
- Three or more providers (non-affiliated) prescribing abuse potential medications in two months within the past twelve months of Medicaid eligibility.
- Six or more prescriptions filled for abuse potential medications in a two-month period within the past twelve months of eligibility.
- Five or more non-emergent Emergency Department visits in the past twelve months of Medicaid eligibility.

ACOs and UMIC plans must consider other considerations when determining placement in the Restriction Program such as member diagnosis, concurrent prescribers, PCP utilization, and other Medicaid utilization patterns, as well as limited access to care in rural areas.

Members enrolled in the Restriction Program are assigned to one PCP, one pharmacy, and PCP-approved specialty providers. Payments to unassigned or unapproved providers are denied by the ACO, UMIC plan, and/or Medicaid. Emergency department services are not restricted, but members receive education regarding urgent care as an available alternative to emergency department care when members' needs are non-emergent.

PCPs participating in the Restriction Program manage the restricted member's medical care, approving of secondary prescribers and referring members to necessary specialty providers as needed. PCPs provide education regarding appropriate use of medical services and are telephonically available 24 hours per day / seven days per week for emergencies (or assure telephonic access to other similarly skilled clinicians on a 24/7 basis). PCPs also provide management of acute and/or chronic long-term pain through a variety of modalities including referral to pain management specialty providers and other specialty providers as needed.

Coordination of care is facilitated by the PCP by sharing pertinent information regarding the member with mental health providers, pain management providers, and other approved medical specialty providers.

ACOs and UMIC plans provide contact information to restricted members to facilitate access to appropriate Restriction staff. Assistance to restricted members is provided throughout the duration of the members' Restriction Program enrollment in the form of problem-solving, education and pro-active case management.

ACOs and UMIC plans review member placement on the Restriction Program on an annual basis. Members who have followed Restriction program guidelines and no longer meet Restriction criteria are discharged from the Restriction Program. Members found to continue to meet one or more of the restriction criteria, remain enrolled in the Restriction Program.

The Restriction Program effectively implements the Quality Strategy goal to deliver more affordable care through innovative strategies in partnership with ACOs, UMIC plans, and other stakeholders. It does this by managing high-cost members through electronically restricting payments to only those providers approved by the PCP and assisting members in more effectively managing their health care, thereby decreasing excessive use of Medicaid services and driving down costs of healthcare.

Mental Health Surveys

To review quality issues such as performance and timely access, PMHPs administer satisfaction surveys under the direction of the Division of Substance Abuse and Mental Health.

These include the Mental Health Statistics Improvement Program, Youth Services Survey and Youth Services Survey-Family. The data gathered from these surveys provide valuable information to assist PMHPs in delivering more effective care.

Outcomes Project

The Utah Public Mental Health system participates in a state-of-the-art initiative designed to assess the outcomes of mental health treatment to improve the care provided. The state adopted the use of nationally recognized outcomes questionnaires, the Outcomes Questionnaire© (OQ) for adults and the Youth Outcomes Questionnaire© (YOQ) for youth. These tools provide mental health clinicians' immediate feedback on the effectiveness of the treatment provided. These tools also provide clinical guidance to improve care, when needed.

Intermediate Sanctions

Per 42 CFR § 438.700, DMHF may impose intermediate sanctions to address quality of care problems when an ACO, UMIC plan, PMHP, or Dental plan fails to comply with contract and/or federal requirements. DMHF provides written notice before imposing any intermediate sanction. The plan may request a state fair hearing if they disagree with the sanction.

DMHF may impose the following intermediate sanctions for ACO, UMIC, and Dental plans:

- Civil monetary penalties in the amounts specified in 42 CFR § 438.704.
- Appointment of temporary management of the Contractor as provided in 42 CFR § 438.706 and the Contract.
- Granting members, the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of all new enrollment, including default enrollment, after the effective date of sanction.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

DMHF may impose the following sanctions for a PMHP:

- Requiring the PMHP to meet the terms of a CAP as directed by DMHF.
- Withholding capitation payments.
- Any other remedy as allowed by law.

The inclusion of these intermediate sanctions in DMHF contracts assists in addressing any identified quality of care problems.

DMHF may also utilize liquidated damages if an ACO, UMIC, or Dental plan fails to perform or does not perform on-time provisions under the contract. The liquidated damages that may be imposed are as follows, as described in Article 14.3, Liquidated Damages:

- \$300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;
- \$400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;
- \$1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 13.3) or the Post Adjudication Pharmacy file (as required by Article 4.14.8);
- \$1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 13.3) or Post Adjudication History file (as required under Article 4.14.8);
- \$2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the time frames established under Article 11.2.5.
- \$500 per calendar day the Contractor fails to submit or comply with a CAP;

- \$500 per calendar day that the Contractor fails to provide audit access as required by Article 14.1;
- \$1,000 per calendar day for each day that the Contractor does not comply with the fraud and abuse provision found in Article 6 and such failure requires Department interventions;
- \$5,000 per calendar day that the contractor fails to maintain a complaint and appeal system as required by this Contract and such failure requires Department intervention;
- \$500 per calendar day for other violation of 42 CFR § 438 which requires Department intervention or supervision.

Health Information Technology (HIT)

DMHF uses a variety of informatics sources and systems to conduct managed care operations and evaluate the effectiveness of care and services provided to Medicaid and CHIP members. UDOH has requirements to ensure that contracted entities also have effective information systems, data gathering, and integration processes to conduct ongoing and annual self-evaluation activities.

The Medicaid Managed Care System (MMCS) supports the administration of all Medicaid and CHIP plans. This includes enrollment, disenrollment, capitations, encounter processing, contract management, EPSDT support, etc. All plans have access to MMCS so that they can produce reports on their members. Data from the MMCS is also shared in the state's data warehouse. The state's data warehouse holds information about encounters from managed care plans, fee-for-service claims and provider and recipient information.

The All Payer Claims Database (APCD) provides another source of data review. Payers submit claims data to the APCD through OHCS. The APCD enables the calculation of a patient's total cost of care, which is a key metric in the evaluation of most healthcare reform pilots, including those that will be funded by the SIM grant. DMHF is also able to produce a variety of quality-related reports that assist in the ongoing operation and review of the Quality Strategy. This further enhances the use of this database in assisting with quality improvement for Medicaid's managed care plans and the health care system throughout Utah.

UDOH also has the Indicator-Based Information System for Public Health (IBIS-PH) to integrate public health data from across the Department. IBIS-PH includes 180+ indicator reports which are continuously updated to provide information on important public health measures. UDOH and other public health partners regularly analyze these measures to track and evaluate their progress towards goals. IBIS-PH will serve to enhance the Quality Strategy by providing important information about public health measures that will assist DMHF in the Quality Strategy goals of coordination of care, preventive care and improved quality of services.

Medicaid Promoting Interoperability Program

In addition to utilizing current data systems, DMHF is engaged in innovative HIT initiatives that support the objectives of the Quality Strategy and ensure DMHF is progressing towards the Quality Strategy goals. DMHF is participating in the Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Program) through CMS and the Office of the National Coordinator for Health Information Technology. This program aims to improve the quality of patient care coordination, ensure patient safety and facilitate patient involvement in treatment options by encouraging adoption and meaningful use of certified electronic health record (EHR) technology.

In October 2011 Utah received approval from CMS to make incentive payments to eligible Medicaid providers as they adopt, implement, upgrade or demonstrate meaningful use of EHR technology. Meaningful use includes electronically capturing health information and using it to track conditions and communicate information for care coordination. As of December 31, 2019, 44 hospitals and almost 1200 unique providers have participated in the program.

Utah Medicaid has also coordinated federal funding for several initiatives that align with the Promoting Interoperability goals. These projects include:

- A pediatric patient portal to provide clinicians and parents with access to enhanced health information exchange for children with special healthcare needs.
- Enhancements to Utah's Controlled Substance Database, which facilitates care coordination for patients who receive controlled substance medications such as opioids.
- Improvements to Newborn Screening infrastructure to assist with early identification and timely clinical management of babies born with life-threatening disorders.

Utah's participation in the Promoting Interoperability Program helps DMHF progress towards the Quality Strategy objective of improving the quality of services provided to members by ensuring timely and accurate data through EHRs, improving patient and family engagement, and improving care coordination between Medicaid providers.

PRISM (Provider Reimbursement Information System for Medicaid)

DMHF is transitioning to a new state-of-the-art Medicaid Management Information System (MMIS), called PRISM. The PRISM system will support functional requirements for the Medicaid and CHIP programs and help maximize efficiency and cost-effectiveness.

PRISM development is currently underway and is expected to be fully operational in 2022. PRISM will include the capacity for DMHF to produce quality measures that will support continued quality improvement for the managed care plans. In the interim, Medicaid and CHIP

programs use the existing Medicaid Managed Care System (MMCS) to monitor and drive improvement in managed care.

Utah Health Information Network (UHIN) and Clinical Health Information Exchange (cHIE)

cHIE is Utah's electronic health information exchange and is operated by Utah's Health Information Network (UHIN). In September of 2012, as the result of House Bill 46, Medicaid and CHIP members are automatically enrolled in the cHIE. These families are notified about how to opt-out if they do not wish to participate during their application/renewal process for benefits.

The four major Utah healthcare systems, several large clinics, rural hospitals, and many independent practices are in various stages of joining the cHIE to exchange shared information for patients to improve quality of care and reduce costs. Subsequent updates to the Quality Strategy will include an update on enrollment and progress with the cHIE.

Section V: Delivery System Reforms

The managed care delivery system in Utah is inclusive of many populations as well as quality services for them. Populations served through managed care in the Utah Medicaid program include the aged, blind, disabled, uninsured children in families who qualify, children with special health care needs, foster care children, pregnant women, caretaker adults, and dual eligible individuals. Services include dental, behavioral health, and substance use services. The Utah Medicaid program does not currently include managed care long-term care services and supports.

As described in the Program Background, the integration of physical and behavioral health services through the UMIC plans represents a significant delivery system reform for the Adult Expansion population.

Section VI: Conclusions and Opportunities

Successes

- Thus far, the ACO, full risk managed care model has been successful by providing better control over the rate of cost increases, while providing access to quality of care and care coordination for Medicaid and CHIP members. The state will continue to work with decisions makers, stakeholders, the community and our managed care partners to improve the quality of care for Medicaid and CHIP members while acting as responsible stewards of taxpayer funds.
- The establishment of Utah Medicaid's ACOs in 2013 was followed by the development of the quality measures table for annual tracking purposes. Utah's managed care plans have performed well on these measures in the past compared to the national averages. Continued focus on these measures through the ACOs and UMIC Plans will serve to further improve the quality of services provided to Medicaid members.
- DMHF's transition to PRISM, a new information management system, offers a great opportunity to implement and utilize a new data system that will enhance the implementation and review of the Quality Strategy goals.
- The HIT (Health Information Technology) Incentive provided another avenue to help achieve Quality Strategy goals by improving the quality of services provided to members by ensuring timely and accurate data transmission through EHRs (Electronic Health Records).
- The state's healthcare clearinghouse cHIE (Clinical Health Information Exchange) service allows DMHF, managed care entities to exchange clinical records for real-time care coordination resulting in better outcomes.
- In January 2020, DMHF created four integrated health plans (UMIC) to manage both physical and behavioral health services for the adult expansion populations within Davis, Salt Lake, Utah, Washington, and Weber counties.

Ongoing Challenges

- Fragmented care between physical and behavioral health continues to be a challenge for DMHF and its managed care plans. Behavioral health services for Medicaid members in Utah are primarily provided through PMHPs under the supervision of individual counties. Physical health services for Utah Medicaid members enrolled in managed care are received through the ACOs. The separation of these delivery models presents ongoing challenges in providing seamless and coordinated care to Medicaid members. The initiation of the UMIC plans is one of the major efforts BMHC is pursuing to address these gaps of care. DMHF also sees several opportunities for improved integration of physical and behavioral health services and has included these opportunities in the Quality Strategy through different objectives and interventions. Review and analysis of these will reflect the success of DMHF, the ACOs, and the PMHPs in addressing this important challenge.

- As DMHF continues to manage many major initiatives including continued oversight of the MCEs, PRISM development and implementation, and health care reform, organizational resources will be used at full capacity. DMHF will have to continue to prioritize the goals and objectives of the Quality Strategy to continue to move the work of quality improvement forward. This will ensure improved care for members through higher-value managed care plans.

Current and Future Initiatives

- Utah Medicaid/CHIP will improve in the areas of care coordination, preventive care for women and children, access to and quality of services provided, and innovative strategies for controlling costs while maintaining and improving quality of care.
- DMHF and its contracted managed care entities are actively engaged in the following: Working with partners and stakeholders to modify the funding for behavioral health services which will allow greater flexibility to implement additional integrated care models
- Exploring reimbursement policies to encourage and support care integration at the clinical level
- Participating in a new effort to find more effective ways to better address the social determinants of health
- Implementing efforts to inform, encourage and facilitate COVID 19 vaccinations for Medicaid members
- Exploring ways to increase well child care and immunizations for children

Section VII: Appendix A

Glossary of Acronyms

ACO-Accountable Care Organization

APCD-All Payer Claims Database

BMHC-Bureau of Managed Health Care

CAHPS- Consumer Assessment of Healthcare Providers and Systems

CAP-Corrective Action Plan

CHCD-Choice of Health Care Delivery Waiver

CHIE-Clinical Health Information Exchange

CHIP-Children's Health Insurance Program

CHIPRA-Children's Health Insurance Program Reauthorization Act

DMHF -Division of Medicaid and Health Financing

DWS-Department of Workforce Services

EHR-Electronic Health Record

EQR-External Quality Review

EQRO-External Quality Review Organization

FFS-Fee-for-Service

HCU- Health Choice Utah

HEDIS- Healthcare Effectiveness Data and Information Set

HIE-Health Information Exchange

HIT-Health Information Technology

HOME-Health Outcomes Medical Excellence Program HSAG-Health Services Advisory Group

HU-Healthy U

IBIS-PH-Indicator-Based Information System for Public Health

IPR-Individual Plan Report

MCAC-Medicaid Medical Care Advisory Committee

MCE-Managed Care Entity

MCO-Managed Care Organization

MHU-Molina Healthcare of Utah

MMCS-Medicaid Managed Care System

MMIS-Medicaid Management Information System

OHCS-Office of Health Care Statistics

OQ-Outcomes Questionnaire

PAHP-Prepaid Ambulatory Health Plan

PCP-Primary Care Provider

PIHP-Prepaid Inpatient Health Plan

PIP-Performance Improvement Project

PMHP-Prepaid Mental Health Plan

SHCC-Select Health Community Care

SIM-State Innovation Models

QIC-Quality Improvement Council

UDOH-Utah Department of Health

UHIN-Utah Health Information Network

UMIC-Utah Medicaid Integrated Care

YOQ-Youth Outcomes Questionnaire

Appendix B – Clinical Practice Guidelines

Clinical Practice Guidelines

Position Statement: University of Utah Health Plans adopts guidelines to help practitioners and members make decisions about appropriate care for specific medical and behavioral health conditions. The following guidelines are based on scientific evidence, and where evidence is lacking, on a consensus of panel experts, and are supported by University of Utah Health Plans. Guidelines are not a substitute for professional medical advice.

Behavioral Health Guidelines	
Category	Resource
Depression	Practice guideline for the Treatment of Patients with Major Depressive Disorder
Attention Deficit Hyperactivity Disorder (ADHD)- Pediatrics	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
Attention Deficit Hyperactivity Disorder (ADHD)- Adults	European Consensus Statement for the Diagnosis, Management, and Treatment of Adult ADHD
Substance Use Disorder	Implementing Care for Alcohol and Other Drug Use in Medical Settings
Opioid Prescribing	CDC Guideline for Prescribing Opioids for Chronic Pain
Medical Guidelines	
Category	Resource
Asthma	Global Initiative for Asthma (GINA) Report, Global Strategy for Asthma Management and Prevention
Congestive Heart Failure	Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Failure Society of America
Preventive Health Guidelines	
Category	Resource
Immunizations- Pediatric	Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States
Well Child Visits- Pediatric	American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care Additional Resources

Mammography	United States Preventive Services Task Force (USPSTF) Breast Cancer Screening for Adult Women
Screening for Perinatal Depression	American College of Obstetrics and Gynecologists (ACOG) Screening for Perinatal Depression
Colorectal Cancer Screening	United States Preventive Services Task Force (USPSTF) Colorectal Cancer Screening
Immunizations	Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged 19 Years and Older, United States
Adult Preventive Services	United States Preventive Services Task Force (USPSTF) Recommendations for Primary Care Practice, Adult

Appendix C – ACO Network Adequacy

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. In establishing and maintaining the network of Network Providers the Contractor must consider the following:

- (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 contracted Medicaid 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, and whether the location provides physical access for Medicaid Enrollees with disabilities.

(B) The Contractor shall ensure that each Enrollee is able to choose his or her Network Provider to the extent possible and appropriate.

5.1.2 Women's Health Specialists

The Contractor shall provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist.

5.1.3 Second Opinions

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

5.1.4 Out of Network Services

(A) If the Contractor's network of Network Providers is unable to provide Medically Necessary 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.

5.1.5 Timely Access

The Contractor and its Network Providers shall meet the Department's standards for timely access to care and services, as described in Article 10.2.6, considering the urgency of need for services. The Contractor shall require that its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or Medicaid Fee-For-Service enrollees, if the Network Provider serves only Medicaid Enrollees. The Contractor shall ensure that all Covered Services are available 24 hours a day, 7 days a week, when Medically Necessary.

5.1.6 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements, 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.

5.2 Subcontracts and Agreements with Providers

5.2.1 Subcontracts, Generally

(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) The Contractor shall ensure, if any of the Contractor's activities or obligations under this Contract are delegated to a Subcontractor:

(1) The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Contractor and the Subcontractor.

(2) The contract or written arrangement between the Contractor and the Subcontractor

must either provide for the revocation of the delegation of activities or obligations, or specify 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 comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.

(D) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(E) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(F) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(G) Contracts between the Contractor and any Subcontractor shall require that if the Department, CMS, or the Department of Health and Human Services Inspector General determine 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 inform Providers and Subcontractors at the time it enters into a contract with the Provider or Subcontractor about:

(1) Enrollee Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 CFR § 438.400 through 42 CFR § 438.424;

(2) Enrollee's right to file Grievances and Appeals and the requirements and timeframes for filing;

(3) The availability of assistance to the Enrollee with filing Grievances and Appeals;

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

(5) the Enrollee's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within the allowable timeframes, and that the Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee.

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

(C) The Contractor's written agreements with its Subcontractors and Providers shall contain a provision stating that if the Subcontractor or Provider becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Subcontractor or Provider.

5.2.3 Other Network Provider Requirements

(A) The Contractor shall ensure that its Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act prohibiting the Contractor Providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

(B) The Contractor shall ensure that 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) All of the Contractor's Network Providers shall be aware of the Contractor's Quality Assessment and Performance Improvement Plan (QAPIP) and activities. All of the Contractor's agreements with Network Providers 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 either enrolled with the Department as a Fee-For-Service provider or are enrolled with the Department as a “limited enrollment provider.”

5.3 Contractor’s Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

The Contractor shall make a payment only to a Provider who is enrolled with the Department as a full or limited Medicaid Provider.

5.3.2 Network Provider Selection, Generally

(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. The Department will provide the Contractor 60 days advance written notice of any changes to the Department’s network Provider selection requirements.

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. The Contractor’s written policies and procedures shall follow the Department’s policies that require:

- (1) Network Provider completion of Contractor written applications;
- (2) Procedures for assuring that potential and current Network Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (3) Primary source verification of licensure and disciplinary status by the State of Utah and other states;
- (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

(A) The Contractor shall have a re-credentialing process for Network Providers that:

- (1) Is completed at least every three years; and

(2) Updates information obtained during the initial credentialing process.

5.3.5 Notifications

The Contractor shall have procedures for notifying the Utah Department of Professional Licensing 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 recredentialing policies and procedures.

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 the Department of Occupational and Professional Licensing'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

The Contractor must enter into a subcontract with at least one Federally Qualified Health Center ("FQHC"). The Contractor shall reimburse the FQHC an amount not less than what the Contractor pays comparable Providers that are not FQHCs.

5.3.10 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall develop or adopt practice guidelines consistent with current standards of care as recommended by professional groups such as the American Academy of Pediatrics and the U.S. Preventative Services Task Force. The practice guidelines shall meet the following requirements:

(1) Guidelines shall be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(2) Guidelines shall consider the needs of the Contractor's Health Plan Enrollees;

(3) Guidelines shall be adopted in consultation with contracting health care professionals; and

(4) Guidelines shall 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 and Potential Enrollees.

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

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 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 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.

5.4.2 Special Rules for Payment for Provider Preventable Conditions

(A) The Contractor shall ensure compliance with the requirements mandating Provider identification of Provider-Preventable Conditions as a condition of payment. The Contractor shall require that its Network Providers identify Provider Preventable Conditions in a form or frequency as specified by the Department.

(B) The Contractor shall not pay for Provider-Preventable conditions as set forth in 42 CFR § 434.6(a)(12) and 447.26, Utah Administrative Rule, and as noted in the Utah State Plan Attachments 4.19-A and 4.19-B.

5.4.3 Vaccines for Children Program

(A) The Contractor shall not reimburse Providers for the cost of vaccines that are purchased through the federal Vaccines for Children Program. However, the Contractor shall be responsible for paying the vaccine administration fee.

(B) The Contractor shall not include pre-paid vaccine payment errors in its Encounter Data.

5.5 Prohibitions on Payment

5.5.1 Prohibitions on Payments for Excluded Providers

(A) In accordance with Section 1903(i)(2)(A) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished:

(1) under the Health Plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

(2) at the medical direction or prescription of a physician, during the period when such physician is excluded from participation under Title V, XVII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(3) by any individual or entity to whom the Department has failed to suspend payments during any period when there is a pending allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments.

(C) If the Contractor suspends payment pursuant to Article 5.6.1(A)(3) of this Contract, the Contractor shall immediately send written notice to the Department of its intent to suspend payment and shall supply any information regarding the suspension and the allegation of fraud as requested by the Department.

5.5.2 Additional Payment Prohibitions under Federal Law

(A) In accordance with Section 1903(i)(16), (17) and (18) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than emergency item or service, not including items or services furnished in an emergency room of a hospital):

(1) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

(2) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan; and

(3) for home health care services provided by an agency or organization, unless the agency provides the Contractor or the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

5.5.3 Availability of FFP

(A) Pursuant to Section 1903(i)(2), 42 CFR § 438.808, § 1001.1901(c), and § 1002.3(b)(3), FFP is

not available for any amounts paid to the Contractor for any of the following reasons:

(1) the Contractor is controlled by a sanctioned individual as described in § 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 nonprocurement 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 any of the following:

(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 (FAR) or from participating in nonprocurement 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 nonprocurement 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.

Appendix D – UMIC Network Adequacy

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 must 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 each Enrollee is able to choose his or her Network Provider to the extent possible and appropriate.

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

5.1.2 Time and Distance Standards

(A) The Contractor shall maintain provider network adequacy time and distance standards to ensure Enrollee access as described in Table 1 - Time and Distance Standards.

(B) Per CMS regulations, the contractor shall ensure that Enrollees have access to the following types of providers within the time and distance standards.

TABLE 1 - Time and Distance Standards

Provider or Facility Type	Standard
Primary Care	90% of Enrollees must have access within 10 miles or 15 minutes
OB/GYN	90% of Enrollees must have access within 10 miles or 15 minutes
Specialist	90% of Enrollees must have access within 30 miles or 45 minutes
Hospital	90% of Enrollees must have access within 30 miles or 45 minutes
Pharmacy	90% of Enrollees must have access within 10 miles or 15 minutes
Behavioral health (mental health and substance use disorder)	90% of Enrollees must have access within 10 miles or 15 minutes

(C) If the Contractor is unable to meet the network adequacy standards described in this Article 5.1.2, 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.

5.1.3 Women’s Health Specialists

The Contractor shall provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist.

5.1.4 Second Opinions

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

5.1.5 Out of Network Services

(A) If the Contractor's network of Network Providers is unable to provide Medically Necessary 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.

5.1.6 Credentials

The Contractor shall demonstrate that its Network Providers are credentialed as required by 42 CFR § 438.214.

5.1.7. Family Planning

The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to Covered Services.

5.1.8 Timely Access

The Contractor and its Network Providers shall meet the Department's standards for timely access to care and services, as described in Article 10.2.6, taking into account the urgency of need for services. The Contractor shall require that its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or FFS enrollees, if the Network Provider serves only Medicaid Enrollees. The Contractor shall ensure that all Covered Services are available 24 hours a day, 7 days a week, when Medically Necessary.

5.1.9 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements found in Article 10.2.6, 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.

5.2 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 must either provide for the revocation of the delegation of activities or obligations, or specify 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.

(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 Subcontractors and Providers

(A) The Contactor shall inform Subcontractors and Providers at the time it enters into a contract with the Subcontractor or a Network Provider agreement with a Provider about:

(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 to the Enrollee 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 which is adverse to the Enrollee; and

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

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

(C) The Contractors written agreements with its Subcontractors and Providers shall contain a provision stating that if the Subcontractor or Provider becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Subcontractor or Provider.

5.2.3 Additional Network Provider Requirements

- (A) The Contractor shall ensure that its Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act prohibiting the Contractor's Providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary Covered Services provided to Enrollees.
- (B) The Contractor shall ensure that 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 all Network Providers are aware of the Contractor's Quality Assessment and Performance Improvement Plan (QAPIP) and activities. All of the Contractor's Network Provider agreements with Network Providers 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 all of its Network Providers are either enrolled with the Department as a FFS provider or are enrolled with the Department as a full or limited Medicaid provider.

5.2.4 Mandatory Network Contracts

- (A) The contractor must contract with:
 - (1) a level one trauma facility;
 - (2) a trauma intensive care burn center that includes:
 - (i) an operating room;
 - (ii) burn therapy services;
 - (iii) outpatient departments;
 - (iv) support activities for burn survivors; and
 - (v) service for both adults and children.
 - (3) Primary Children's Hospital;
 - (4) PMHP Contractors operating in the Contractor's Service Area, except in Salt Lake County; and
 - (5) Essential Providers.
- (B) If the Contractor is unable to attain a commercially reasonable and actuarially sound contract

with the providers listed in 5.2.4(A), the Contractor may present an alternative plan for approval by the Department to ensure network adequacy is maintained.

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

(A) The Contractor shall make a payment only to a Provider who is enrolled with the Department as a full or limited Medicaid Provider, except when:

- (1) the Provider is a Non-Network provider under single case agreements;
- (2) the Provider is an emergency provider that does not meet the definition of a Network Provider per 42 CFR § 438.2; or
- (3) the Provider is a Network Provider, pending enrollment with the Department, per 438.602(b)(2).

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

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

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

(D) The Contractor shall notify affected Enrollees and ensure they are transitioned to other appropriate Providers when the Contractor terminates a Network Provider agreement.

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

5.3.2 Network Provider Selection

(A) The Contractor shall implement written policies and procedures for selection and retention of Network Providers. The policies and 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. The Department will provide the Contractor 60 days advance written notice of any changes to the Department's network Provider selection requirements.

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. The Contractor's

written policies and procedures shall follow the Department's policies that require:

- (1) Network Provider completion of Contractor written applications;
- (2) procedures for assuring that potential and current Network Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (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.

(B) The Contractor shall credential the PMHP Contractors through a facility/organizational credentialing application process.

5.3.4 Timeframe for Re-Credentialing

(A) The Contractor shall have a re-credentialing process for Network Providers.

(B) The Contractor's re-credentialing process shall include that:

- (1) the process is completed at least every three years; and
- (2) the process updates information obtained during the initial credentialing process.

5.3.5 Notifications

The Contractor shall have procedures for notifying the Utah Division of Occupational and Professional Licensing 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.

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

the Department of Occupational and Professional Licensing'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's 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 enter into a Network Provider agreement with all FQHC providers within the Service Area, except as described in 5.3.9(B).

(B) The Contractor shall not be responsible to enter into a Network Provider agreement with FQHC providers designated as an Indian health care program operated by Indian Health Services, or by an Indian Tribe, Tribal Organization, or an Urban Indian Organization.

(C) The Contractor shall reimburse the FQHC providers an amount not less than what the Contractor

pays comparable Providers that are not FQHC providers.

5.3.10 Network Provider Practice Guidelines

Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall adopt practice guidelines consistent with current standards of care. The practice 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 contracting health care professionals; 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 shall ensure that decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply are 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.

5.4 Payment of Provider Claims

5.4.1 Payments to PMHP Contractors and Essential Providers

(A) The Contractor shall reimburse all PMHP Contractors and Essential Providers using the fee schedule determined by the Department.

(B) The Contractor shall pay PMHP Contractors and Essential Providers for additional services as outlined in Article 1.3.22 of Attachment C.

5.4.2 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.

5.4.3 Special Rules for Payment for Provider Preventable Conditions

(A) The Contractor shall ensure compliance with the requirements mandating Provider identification of Provider-Preventable Conditions as a condition of payment. The Contractor shall require that its Network Providers identify Provider Preventable Conditions in a form or frequency as specified by the Department.

(B) The Contractor shall not pay for Provider-Preventable conditions as set forth in 42 CFR § 434.6(a)(12) and 447.26, Utah Administrative Rule, and as noted in the Utah State Plan Attachments 4.19-A and 4.19-B.

5.5 Prohibitions on Payments

5.5.1 Prohibitions on Payments for Excluded Providers

(A) In accordance with Section 1903(i)(2)(A) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished:

(1) Under the Contractor's Integrated Care Plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

(2) At the medical direction or prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or

(3) By any individual or entity to whom the Department has failed to suspend payments during any period when there is a pending allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments.

(B) If the Contractor suspends payment pursuant to Article 5.5.1(A)(3) of this Contract, the Contractor shall immediately send written notice to the Department of its intent to suspend payment

and shall supply any information regarding the suspension and the allegation of fraud as requested by the Department.

5.5.2 Additional Payment Prohibitions under Federal Law

(A) In accordance with Section 1903(i)(16), (17) and (18) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than emergency item or service, not including items or services furnished in an emergency room of a hospital):

- (1) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
- (2) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan; and
- (3) for home health care services provided by an agency or organization, unless the agency provides the Contractor or the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

5.5.3 Availability of FFP

(A) Pursuant to Section 1903(i)(2), 42 CFR § 438.808, § 1001.1901(c), and § 1002.3(b)(3), FFP is not available for any amounts paid to the Contractor if:

- (1) the Contractor is controlled by a sanctioned individual as described in § 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 any of the following:

(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.

Appendix E – PMHP Network Adequacy

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 must 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 must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities.

(C) The Contractor shall ensure that each Enrollee is able to choose his or her Network Provider to the extent possible and appropriate.

5.1.2 Second Opinions

The Contractor shall provide for a second opinion from a 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

The Contractor shall require that its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or Medicaid Fee-For-Service enrollees, if the Network Provider serves only Medicaid Enrollees. The Contractor shall ensure that all Covered Services that are Medically Necessary are available 24 hours a day, 7 days a week.

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 Subcontractors and Providers

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

(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 Determinations to reduce, suspend or

terminate services:

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

(C) The Contractor's written agreements with its Subcontractors and Providers shall contain a provision stating that if the Subcontractor or Provider becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Subcontractor or Provider.

5.2.3 Additional Network Provider Requirements

(A) The Contractor shall ensure that its Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act prohibiting the Contractor Providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Covered Services provided to Enrollees.

(B) The Contractor shall ensure that 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 all Network Providers are aware of the Contractor's QAPIP and activities. All of the Contractor's Network Provider agreements with Network Providers 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 all of its Network Providers are enrolled as Utah Medicaid providers.

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

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:

(1) the Provider is a Non-Network Provider under a single case agreement;

(2) the Provider is an emergency provider that does not meet the definition of a Network Provider per 42 CFR § 439.2: or

(3) the Provider is 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 Enrollees and ensure they are transitioned 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, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (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

(A) The Contractor shall have a recredentialing process for Network Providers.

(B) The Contractor's recredentialing process shall include that:

- (1) the process is completed at least every three years; and
- (2) the process updates information obtained during the initial credentialing process.

5.3.5 Notifications

The Contractor shall have procedures for notifying the Utah Division of Occupational and Professional Licensing 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.

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 the Department of Occupational and Professional Licensing'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 § 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; or
 - (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 contracting health care professionals; 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 shall ensure that decisions for utilization management, Enrollee education,

coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.

Appendix F – Dental Network Adequacy

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. In establishing and maintaining the network of Network Providers the Contractor must consider the following:

- (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 contracted Medicaid 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, and whether the location provides physical access for Medicaid Enrollees with disabilities.

(B) The Contractor shall ensure that each Enrollee is able to choose his or her Network Provider to the extent possible and appropriate.

5.1.2 Sufficiency of Network

(A) The Contractor shall have sufficient specialists in its network to serve the population of Enrollees while minimizing travel time for Enrollees.

(B) The Contractor shall have sufficient Network Providers to meet the following time and distance standards:

- (1) in the Wasatch Front and designated Urban Counties, 95% of Enrollees must have access to a Network Provider within 15 Miles or 30 Minutes;
- (2) in the designated Rural Counties, 85% of Enrollees must have access within 75 miles

or 90 minutes;

(3) in the designated Frontier Counties, 75% of Enrollees must have access within 100 miles or 120 minutes.

(C) The Contractor shall be required to contract with the following, if located in the counties where they are contracted to serve:

(1) Primary Children's Hospital

(2) Family Dental Plan

(3) Federally Qualified Health Center (FQHC) as described in Article 5.3.9 of this contract

(4) Rural Health Clinics (RHC)

(D) If the Contractor is unable to meet the network adequacy standards described in this Article 5.1.2, the Contractor may request an exception to these standards. The Department has sole discretion to allow for any exception to the network adequacy standards found in Article 5.1.2.

A request for exception to these standards must be in writing and must include the following:

(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,

(3) a description of the Contractor's plan to adequately provide Covered Services if the exception is granted.

5.1.3 Appointments & Waiting Times

The Contractor shall comply with the following benchmarks for dental providers:

(A) Within 21 days for routine, non-urgent appointments

(B) Same day for urgent care that can be treated in a Provider's office

5.1.4 Second Opinions

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

5.1.5 Out of Network Services

(A) If the Contractor's network of Network Providers is unable to provide Medically Necessary 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 by a Network Provider.

5.1.6 Timely Access

The Contractor shall require that its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or Medicaid Fee-For-Service enrollees, if the Network Provider serves only Medicaid Enrollees. The Contractor shall ensure that all Covered Services are available 24 hours a day, 7 days a week, when Medically Necessary.

5.1.7 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements, 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.

5.2 Subcontracts and Agreements with Providers

5.2.1 Subcontracts, Generally

(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) The Contractor shall ensure, if any of the Contractor's activities or obligations under this Contract are delegated to a Subcontractor:

(1) The activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Contractor and the Subcontractor.

(2) The contract or written arrangement between the Contractor and the Subcontractor must either provide for the revocation of the delegation of activities or obligations, or specify 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 comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.

(D) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(E) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(F) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to 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.

(G) Contracts between the Contractor and any Subcontractor shall require that if the Department, CMS, or the Department of Health and Human Services Inspector General determine 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 Contactor shall inform Providers and Subcontractors at the time it enters into a contract with the Provider or Subcontractor about:

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

reduce or terminate during an Appeal or State Fair Hearing filing, if filed within the allowable timeframes, and that the Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee.

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

(C) The Contractor's written agreements with its Subcontractors and Providers shall contain a provision stating that if the Subcontractor or Provider becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Subcontractor or Provider.

5.2.3 Other Network Provider Requirements

(A) The Contractor shall ensure that its Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act prohibiting the Network Providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

(B) The Contractor shall ensure that 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) All of the Contractor's Network Providers shall be aware of the Contractor's Quality Assessment and Performance Improvement Plan (QAPIP) and activities. All of the Contractor's agreements with Network Providers 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 providers who administer 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 with the Department as a provider. The Contractor shall include a provision in its Network Provider agreements that the Network Provider shall be enrolled with the Department as a provider.

(F) The Contractor shall ensure that its Providers who prescribe medication are enrolled with the Department otherwise the Providers' pharmacy claims will not be paid.

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

(A) The Contractor shall ensure all Network Providers are enrolled with the Department consistent with 42 CFR § 438.608(b); 42 CFR § 455.100-106; 42 CFR § 455.400 - 470.

(B) The Department will screen and enroll, and periodically revalidate all Network Providers as Medicaid providers, per 42 CFR § 438.602(b)(1).

(C) The Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the Department that the Network Provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees, consistent with 42 CFR § 438.602(b)(2).

5.3.2 Network Provider Selection, Generally

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

- (1) Network Provider completion of Contractor written applications;
- (2) Procedures for assuring that potential and current Network Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (3) Primary source verification of licensure and disciplinary status by the State of Utah and other states;
- (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

(A) The Contractor shall have a re-credentialing process for Network Providers that:

- (1) Is completed at least every three years; and
- (2) Updates information obtained during the initial credentialing process.

5.3.5 Notifications

The Contractor shall have procedures for notifying the Utah Department of Professional Licensing 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 recredentialing policies and procedures.

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 the Department of Occupational and Professional Licensing'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 of Network Providers.

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

The Contractor must enter into a subcontract with at least one Federally Qualified Health Center ("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 Providers, who are in individual or group practice or who practice in shared facilities, within 30 days of receipt.

(C) The Contractor shall pay 99 percent of all Clean Claims from Providers, who are in individual or group practice or who practice in shared facilities, within 90 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.

5.4.2 Availability of FFP

(A) Pursuant to Section 1903(i)(2), 42 CFR § 438.808, § 1001.1901(c), and § 1002.3(b)(3), FFP is not available for any amounts paid to the Contractor for any of the following reasons:

(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 nonprocurement 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 any of the following:

(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 nonprocurement 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 nonprocurement 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.

5.4.3 Fee Schedule Standards

(A) If the Contractor elects to pay Providers on a fee for service basis, the Contractor shall, at minimum, pay Providers at the same rate as the Medicaid Fee For Service fee schedule in effect of the date of service as well as either:

(1) the enhanced payment in accordance with Utah Medicaid Policy, Dental , Oral Maxillifacial, and Orthodontia Services, Section 7-1, Paragraphs A, B, and C; or
(2) an alternative payment methodology which promotes Enrollee access to care.

(i) Alternative payment methodologies must be approved by the Department prior to implementation.

5.4.4 Subcapitation

(A) During the first year of this Contract, the Contractor shall not use a subcapitated reimbursement methodology to pay Providers.

(B) After the first year of the Contract, the Contractor may submit a proposal to the Department if it wishes to reimburse Providers using a subcapitated reimbursement methodology. Approval of the proposal shall be in the Department's sole discretion.

(C) During the entire effective period of this Contract, the Contractor shall not have subcapitated provider reimbursement agreements in the Frontier or Rural counties.

(D) During the entire effective period of this Contract, the Contractor shall not have subcapitated provider reimbursement agreements that includes Enrollees with Special Health Care needs.

5.5 Network Provider Practice Guidelines

5.5.1 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall develop or adopt practice guidelines consistent with current standards of care as recommended by professional groups such as the

American Academy of Pediatric Dentistry and the U.S. Preventative Services Task Force. The practice guidelines shall meet the following requirements:

- (1) Guidelines shall be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - (2) Guidelines shall consider the needs of the Contractor's Dental Plan Enrollees;
 - (3) Guidelines shall be adopted in consultation with contracting health care professionals; and
 - (4) Guidelines shall 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 and Potential Enrollees.
- (C) The Contractor shall ensure that decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.

Appendix G – HOME Network Adequacy

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, Participating Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract. In establishing and maintaining the network of Participating Providers the Contractor must consider the following:

- (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 contracted Medicaid services;
- (4) The number of Participating Providers who are not accepting new Medicaid patients; and
- (5) The geographic location of Participating Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Medicaid Enrollees with disabilities.

5.1.2 Women's Health Specialists

The Contractor shall provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist.

5.1.3 Second Opinions

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

5.1.4 Out of Network Services

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

(B) The Contractor shall require Non-Participating Providers to coordinate with the Contractor with respect to payment and ensure that the cost to the Enrollee is no greater than the cost of the services furnished within the network.

5.1.5 Timely Access

The Contractor shall require its Participating Providers to offer hours of operation that are no less than the hours of operation offered to commercial enrollees or Medicaid Fee-For-Service enrollees, if the Participating Provider serves only Medicaid Enrollees. The Contractor shall ensure that all Covered Services are available 24 hours a day, 7 days a week, when Medically Necessary.

5.1.6 Timely Access Monitoring

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

5.2 Relationships with Subcontractors and Delegation of Duties

5.2.1 Generally

(A) The Contractor shall ensure that all of its Subcontracts are in writing.

(B) The written agreements with the Subcontractor shall include any general requirements of this Contract that are appropriate to the service or activity being delegated under the Subcontract, including confidentiality requirements and shall assure that all duties of the Contractor under this Contract are performed.

(C) Prior to entering into a Subcontract, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

(D) The Contractor shall oversee and be held accountable for any functions and responsibilities that it delegates to any Subcontractor.

(E) The Contractor shall monitor the Subcontractor's performance on an on-going basis that

shall be subject to formal review according to a periodic schedule established by the Department, consistent with industry standards or state laws and regulations.

(F) If the Contractor identifies in its Subcontractor deficiencies or areas of improvement, the Contractor and the Subcontractor shall take corrective action.

(G) No Subcontract shall terminate or limit the legal responsibility of the Contractor to the Department to assure that all activities under this contract are carried out. The Contractor is not relieved of its contractual responsibilities to the Department by delegating those responsibilities to a Subcontractor.

(H) Within 15 days of receiving a request from the Department, the Contractor shall make all Subcontracts available to the Department.

5.2.2 Written Agreements, Specific Requirements

(A) Each of the Contractor's Subcontracts shall contain the following:

(1) A specific description of the activities, service or responsibility being delegated to the Subcontractor;

(2) A provision outlining Contractor's ability to revoke delegation or impose other sanctions if the Subcontractor's performance is inadequate;

(3) A provision stating that if the Subcontractor becomes insolvent or bankrupt Enrollees shall not be liable for the debt of the Subcontractor;

(4) A provision stating that the Subcontractor, acting within the lawful scope of his or her practice, shall not be prohibited from advising or advocating on behalf of an Enrollee who is his or her patient for the following:

(i) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(ii) Any information the Enrollee needs in order to decide among all relevant treatment options;

(iii) The risks, benefits, and consequences of treatment or non-treatment; and

(iv) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; and

(5) Adequate information about the Grievance, Appeal, and State Fair Hearing procedures and timelines so that the Provider can comply with the Grievance and Appeals Systems

requirements including:

- (i) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;
- (ii) The Enrollee's right to file Grievances and Appeals;
- (iii) The requirements and timeframes for filing a Grievance or Appeal;
- (iv) The availability of assistance in the filing process;
- (v) The toll-free numbers that the Enrollee can use to file a Grievance or Appeal by phone;
- (vi) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or request a State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and
- (vii) Any state-determined Provider Appeal rights to challenge the failure of the Contractor to cover a service.

5.2.3 Other Provider-Subcontractor Requirements

(A) The Contractor shall ensure that its Participating Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act prohibiting the Contractor Providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit Medically Necessary services provided to Enrollees.

(B) The Contractor shall ensure that Participating 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 notify all Participating Providers of the Contractor's Quality Assurance Plan and activities. All of the Contractor's agreements with Participating Providers shall include a requirement securing cooperation with the Contractor's Quality Assurance Plan and activities and shall allow the Contractor access to the medical records of Enrollees being treated by Participating Providers.

(D) The Contractor shall require 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 Participating Providers are either enrolled with the Department as a Fee-For-Service provider or are enrolled with the Department as a “limited enrollment provider.”

5.3 Contractor’s Selection of Participating Providers

5.3.1 Provider Enrollment with Medicaid

All Providers to whom the Contractor makes payment must be enrolled with the Department as a full or limited Medicaid Provider.

5.3.2 Participating Provider Selection, Generally

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

5.3.3 Excluded Providers

Pursuant to 42 CFR § 438.214(d), the Contractor shall not employ or contract with Providers that are Excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act.

5.3.4 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 Participating Providers and re-credentialing Participating Providers. The Contractor’s written policies and procedures shall follow the Department’s policies that require:

- (1) Participating Provider completion of Contractor written applications;
- (2) Procedures for assuring that potential and current Participating Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (3) Primary source verification of licensure and disciplinary status by the State of Utah and other states;
- (4) Procedures for viewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension, or exclusion.

5.3.5 Timeframe for Re-Credentialing

(A) The Contractor shall have a re-credentialing process for Participating Providers that:

- (1) Is completed at least every three years; and
- (2) Updates information obtained during the initial credentialing process.

5.3.6 Notifications

The Contractor shall have procedures for notifying the Utah Division of Professional Licensing when it suspects or has knowledge that a Provider has violated Professional Licensing statutes, rules, or regulations.

5.3.7 Documentation

The Contractor shall maintain documentation of its credentialing and re-credentialing activities. Upon request from the Department, the Contractor shall demonstrate that its Participating Providers are credentialed and re-credentialed following Contractor's written credentialing and re-credentialing policies and procedures.

5.3.8 Non-Inclusion of Providers

(A) The Contractor shall report to the Department when a Provider is denied Participating 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 the Department of Occupational and Professional Licensing'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.

5.3.9 Nondiscrimination

(A) Consistent with 42 CFR § 438.214 and 42 CFR § 438.12, the Contractor's Provider selection policies and procedures shall not discriminate against 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.

5.3.10 Federally Qualified Health Centers

(A) The Contractor shall not restrict an Enrollee's right to obtain FQHC services outside the PMHP through the Fee For Service Medicaid program.

(B) If the Contractor subcontracts with an 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 Participating 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 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 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.

5.4.2 Special Rules for Payment for Provider Preventable Conditions

(A) The Contractor shall ensure compliance with the requirements mandating Provider identification of Provider-Preventable Conditions as a condition of payment. The Contractor shall require that its Participating Providers identify Provider Preventable Conditions in a form or frequency as specified by the Department.

(B) The Contractor shall not pay for Provider-Preventable conditions as set forth in 42 447.26, Utah Administrative Rule, and as noted in the Utah State Plan Attachments 4.19-A and 4.19-B.

5.4.3 Vaccines for Children Program

(A) The Contractor shall not reimburse Providers for the cost of vaccines that are purchased through the federal Vaccines for Children Program. However, the Contractor shall be responsible for paying the vaccine administration fee.

(B) The Contractor shall not include pre-paid vaccine payment errors in its Encounter Data.

5.5 Prohibitions on Payment

5.5.1 Prohibitions on Payments for Excluded Providers

(A) In accordance with Section 1903(i)(2)(A) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished:

- (1) under the Health Plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;
- (2) at the medical direction or prescription of a physician, during the period when such physician is excluded from participation under Title V, XVII, or XX of the Social Security Act pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); or
- (3) by any individual or entity to whom the Department has failed to suspend payments during any period when there is a pending allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments.

(B) If the Contractor suspends payment pursuant to Article 5.4.1(A)(3) of this Contract, the Contractor shall immediately send written notice to the Department of its intent to suspend payment and shall supply any information regarding the suspension and the allegation of Fraud as requested by the Department.

5.5.2 Additional Payment Prohibitions under Federal Law

(A) In accordance with Section 1903(i)(16), (17) and (18) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than emergency item or service, not including items or services furnished in an emergency room of a hospital):

- (1) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
- (2) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Plan; and
- (3) for home health care services provided by an agency or organization, unless the agency provides the Contractor or the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

5.5.3 Availability of FFP

(A) Pursuant to Section 1903(i)(2), 42 CFR § 438.808, § 1001.1901(c), and § 1002.3(b)(3), FFP is not available for any amounts paid to the Contractor for any of the following reasons:

- (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 an individual convicted of certain crimes as described in Section 1128(b)(8)(B) 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 any of the following:
 - (i) any individual or entity Excluded from participation in Federal Health Care Programs;
 - (ii) any entity that would provide those services through an Excluded individual

or entity.