UTAH DEPARTMENT OF HEALTH CONTRACT

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

1835204
Department Log Number

182700622
State Contract Number

1. CONTRACT NAME: The name of this contract is ACO - Healthy U Medicaid.

2. CONTRACTING PARTIES: This contract is between the Utah Department of Health (DEPARTMENT) and the following CONTRACTOR:

PAYMENT ADDRESS
UNIVERSITY OF UTAH HEALTH PLANS
6053 FASHION SQUARE DR #110
MURRAY UT, 84107

MAILING ADDRESS
UNIVERSITY OF UTAH HEALTH PLANS
6053 FASHION SQUARE DR #110
MURRAY UT, 84107

Vendor ID: 47425DM
Commodity Code: 94842

3. GENERAL PURPOSE OF CONTRACT: The general purpose of this contract is to provide medical services to Traditional and Non-Traditional Medicaid clients enrolled in the Accountable Care Organization..

4. PROCUREMENT: This contract is entered into as a result of Other Exemption.

5. CONTRACT PERIOD: The service period of this contract is 01/01/2018 through 12/31/2022, unless terminated or extended by agreement in accordance with the terms and conditions of this contract.

6. CONTRACT AMOUNT: The DEPARTMENT agrees to pay $1,500,000,000.00 in accordance with the provisions of this contract.

7. CONTRACT INQUIRIES: Inquiries regarding this Contract shall be directed to the following individuals:

CONTRACTOR

Kelly Peterson
[redacted]

DEPARTMENT

Medicaid and Health Financing
Managed Health Care
Trevor Smith
[redacted]

8. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:

Attachment A: Utah Department of Health General Provisions
Attachment B: Special Provisions
Attachment C: Covered Services (Traditional)
Attachment D: Covered Services (Non-Traditional)
Attachment E: Quality and Performance
Attachment F: Payment Methodology

9. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
   A. All other governmental laws, regulations, or actions applicable to services provided herein.
   B. All assurances and all responses to bids as provided by the CONTRACTOR.

10. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

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Contract with Utah Department of Health and UNIVERSITY OF UTAH HEALTH PLANS, **Log #** 1835204

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: [redacted] 2/8/18

Chad Westover Date
CEO

STATE [redacted]

2/9/2018

By: _____ _____

Shari A. Watkins, C.P.A. Date
Director, Office Fiscal Operations

Attachment A: UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

NON STANDARD PROCUREMENT (NON-RFP)

1. DEFINITIONS

a. “Authorized Persons” means Contractor’s employees, officers, partners, Subcontractors or other agents of Contractor who need to access State Data to enable Contractor to perform its responsibilities under Contract.

b. "Contract" means this agreement between the Department and Contractor, including the Contract Signature Page(s) and all referenced attachments and documents incorporated by reference.

c. “Contract Signature Page(s)” means the cover page(s) that the Department and Contractor sign.

d. "Contractor" means the person who delivers the services or goods described in the Contract.

e. "Department" means the Utah Department of Health.

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

g. “Federal pass through money” means federal money received by a nonprofit corporation through a subaward or contract but does not include federal money received by a nonprofit corporation as payment for goods or services purchased by the Department.

h. “Goods” means any deliverable that is not defined as a Service that Contractor is required to deliver under the Contract.

i. “Local money” means money that is owned, held or administered by a political subdivision of the state that is derived from fee or tax revenues but does not include money received by a nonprofit corporation as payment for goods or services purchased from the nonprofit corporation or contributions or donations received by the political subdivision.

j. “Originating funding entity” means an individual or entity which provided to the Department any or all funds payable under this Contract.

k. “Pass through funding” means money appropriated to a state agency which includes ongoing or one-time money and is designated as general funds, dedicated credits, or any combination of state funding sources, that is intended to be passed through the state agency to a local government entity, private organization, including not-for-profit organizations or persons in the form of a loan or grant.

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

m. “Recipient entity” means a local government entity or private entity, including a nonprofit entity, which receives money by way of pass through funding from the Department.

n. "Services" means the furnishing of labor, time, or effort by Contractor pursuant to this Contract. Services include, but are not limited to, all of the deliverable(s) (including supplies, equipment, or commodities) that result from Contractor performing the Services pursuant to this Contract. Services include those professional services identified in Section 63G-6a-103 of the Utah Procurement Code.

o. "State" means the State of Utah, in its entirety, including its institutions, agencies, departments, divisions, authorities, instrumentalities, boards, commissions, elected or appointed officers, employees, agents, and authorized volunteers.

p. “State Data” means all confidential information, non-public data, personal data, and protected health information that is created or in any way originating with the State whether such data or

output is stored on the Department's hardware, Contractor's hardware, or exists in any system owned, maintained or otherwise controlled by the Department or by the Contractor. State Data includes any federal data that the Department controls or maintains, that is protected under federal laws, statutes, and regulations. The Department reserves the right to identify, during and after the Contract, additional reasonable types of categories of information that must be kept confidential under federal and state laws.

q. "State money" means money that is owned, held or administered by a state agency and derived from state fee or tax revenues but does not include contributions or donations received by the state agency.

r. "Subcontract" means a written agreement between Contractor and another party to fulfill the requirements of the Contract.

s. "Subcontractor" means subcontractors or subconsultants at any tier that are under the direct or indirect control or responsibility of the Contractor, and includes all independent contractors, agents, employees, authorized resellers, or anyone else for whom the Contractor may be liable at any tier, including a person or entity that is, or will be, providing or performing an essential aspect of this Contract, including Contractor's manufacturers, distributors, and suppliers.

t. "Uniform Guidance" means Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards for the specified federal awarding agency set forth in Title 2 of the Code of Federal Regulations.

2. **EFFECTIVE DATE:** Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in the Contract.

3. **GOVERNING LAW AND VENUE**: This Contract shall be governed by the laws, rules, and regulations of the State of Utah. Any action or proceeding arising from the Contract shall be brought in a court of competent jurisdiction in the State of Utah. Venue shall be in Salt Lake City, in the Third Judicial District Court for Salt Lake County.

4. **AMENDMENTS:** The Contract may only be amended by mutual written agreement signed by both parties, which amendment will be attached to the Contract. Automatic renewals will not apply to the Contract, even if listed elsewhere in the Contract.

5. **CHANGES IN SCOPE:** Any changes in the scope of the Services to be performed under this Contract shall be in the form of a written amendment to this Contract, mutually agreed to and signed by both parties, specifying any such changes, fee adjustments, any adjustment in time of performance, or any other significant factors arising from the changes in the scope of Services.

6. **LAWS AND REGULATIONS:** At all times during the Contract, Contractor shall comply with all applicable federal and state constitutions, laws, rules, codes, orders, and regulations, including licensure and certification requirements. If the Contract is funded by federal funds, either in whole or in part, then any federal regulation related to the federal funding will supersede this Attachment A.

7. **CONFLICT OF INTEREST**: Contractor represents that none of its officers or employees are officers or employees of the Department or the State of Utah, unless written disclosure has been made to the Department.

8. **CONFLICT OF INTEREST WITH STATE EMPLOYEES:** Contractor agrees to comply and cooperate in good faith will all conflict of interest and ethic laws, including but not limited to, Section 63G-6a-2404, Utah Procurement Code.

9. **INDEPENDENT CONTRACTORS:** Contractor and Subcontractors, in the performance of the Contract, shall act in an independent capacity and not as officers or employees or agents of the Department or State.

10. **PROCUREMENT ETHICS**: Contractor understands that a person who is interested in any way in the sale of any supplies, services, construction, or insurance to the State of Utah is violating the law if the person gives or offers to give any compensation, gratuity, contribution, loan, reward, or any promise thereof to any person acting as a procurement officer on behalf of the State of Utah, or who in any official capacity participates in the procurement of such supplies, services, construction, or insurance, whether it is given for their own use or for the use or benefit of any other person or organization.

11. **REPORTING RECEIPT OF FEDERAL AND STATE FUNDS**.

    11.1. If Contractor is a nonprofit corporation and receives federal pass through money or state money, Contractor shall disclose to the Department, annually and in writing, whether it has received in the previous fiscal year or anticipates receiving any of the following amounts: (i) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money in the amount of $750,000 or more; (ii) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money at least $350,000 but less than $750,000; or (iii) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money of at least $100,000 but less than $350,000.

    11.2. If Contractor is a recipient entity that, under the terms of the contract, is receiving pass through funding that was neither issued under a competitive award process, nor in accordance with a formula enacted in statute nor in accordance with a state program under parameters in statute or rule that guides the distribution of the pass through funding,

Contractor shall provide to the Department a written description and itemized report at least annually detailing the expenditure of the state money, or the intended expenditure of any state money that has not been spent. Contractor shall provide to the Department a final written itemized report when all the state money is spent. The Department may require Contractor to return an amount of money that is equal to the state money expended in violation of the terms of the section.

12. **INVOICING:** Unless otherwise stated in the Special Provisions of the Contract, Contractor will submit invoices along with any supporting documentation within thirty (30) days following the last day of the month in which the expenditures were incurred or the services provided or within thirty (30) days of the delivery of the Good to the Department. The contract number shall be listed on all invoices, freight tickets, and correspondence relating to this Contract. The prices paid by the Department will be those prices listed in this Contract, unless Contractor offers a prompt payment discount on its invoice. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

13. **PAYMENT**:

13.1. The Department shall reimburse total actual expenditures, less amounts collected by Contractor from any other person not a party to the Contract legally liable for the payments for the goods and services.

13.2. The Department shall make payments within thirty (30) days after a correct invoice is received. All payments to Contractor will be remitted by mail, electronic funds transfer, or the State of Utah's Purchasing Card (major credit card). If payment has not been made after sixty (60) days from the date a correct invoice is received by the Department, then interest may be added by Contractor as prescribed in the Utah Prompt Payment Act. The acceptance by Contractor of final payment, without a written protest filed with the Department within ten (10) business days of receipt of final payment, shall release the Department and the State of Utah from all claims and all liability to Contractor. The Department's payment for the Services shall not be deemed an acceptance of the Services and is without prejudice to any and all claims that the Department or the State of Utah may have against Contractor. Contractor may not charge end users electronic payment fees of any kind.

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

13.4. Upon 30 days written notice, Contractor shall reimburse Department for funds the Department is required to reimburse the grantor or originating funding entity up to the amount repaid resulting from the actions of the Contractor or its Subcontractors.

14. **NONAPPROPRIATION OF FUNDS, REDUCTION OF FUNDS, OR CHANGES IN LAW:** Upon thirty (30) days written notice delivered to the Contractor, this Contract may be terminated in whole or in part at the sole discretion of the Department, if the Department reasonably determines that: (i) a change in Federal or State legislation or applicable laws materially affects the ability of either party to perform under the terms of this Contract; or (ii) that a change in available funds affects the Department's ability to pay under this Contract. A change of available funds as used in this paragraph includes, but is not limited to, a change in Federal or State funding, whether as a result of a legislative act or by order of the President or the Governor.

If a written notice is delivered under this section, the Department will reimburse Contractor for the Services properly ordered until the effective date of said notice. The Department will not be liable for any performance, commitments, penalties, or liquidated damages that accrue after the effective date of said written notice.

15. **INSURANCE:** Contractor shall at all times during the term of the Contract, without interruption, carry and maintain commercial general liability insurance from an insurance company authorized to do business in the State of Utah. The limits of this insurance will be no less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate. Contractor also agrees to maintain any other insurance policies required in any applicable Solicitation. Contractor shall provide proof of the general liability insurance policy and other required insurance policies to the Department within thirty (30) days of contract award. Contractor must add the State of Utah as an additional insured with notice of cancellation. Failure to provide proof of insurance as required will be deemed a material breach of the Contract. Contractor's failure to maintain this insurance requirement for the term of the Contract will be grounds for immediate termination of the Contract.

16. **WORKERS' COMPENSATION INSURANCE:** Contractor shall maintain during the term of this Contract, workers' compensation insurance for all its employees as well as any Subcontractor employees related to this Contract. Workers' compensation insurance shall cover full liability under the workers' compensation laws of the jurisdiction in which the service is performed at the statutory limits required by said jurisdiction. Contractor acknowledges that within thirty (30) days of contract award, Contractor must submit proof of certificate of insurance that meets the above requirements.

17. **SALES TAX EXEMPTION**: The Services under the Contract will be paid for from the Department's funds and used in the exercise of the Department's essential functions as a State of Utah entity. Upon request, the Department will provide Contractor with its sales tax exemption number. It is Contractor's responsibility to request the Department's sales tax exemption number. It is Contractor's sole responsibility to ascertain whether any tax deductions or benefits apply to any aspect of the Contract.

18. **SUSPENSION OF WORK:** Should circumstances arise which would cause the Department to suspend Contractor's responsibilities under this Contract, but not terminate this Contract, this will be done by written notice. Contractor's responsibilities may be reinstated upon advance formal written notice from the Department.

19. **INDEMNIFICATION**:

    19.1. If Contractor is a governmental entity, the parties mutually agree that each party assumes liability for the negligent and wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for the Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.

    19.2. If Contractor is a non-governmental entity, Contractor shall be fully liable for the actions of its agents, employees, officers, partners, and Subcontractors. Contractor shall fully indemnify, defend, and save harmless the Department and the State of Utah from all claims, losses, suits, actions, damages, and costs of every name and description arising out of Contractor's performance of the Contract caused by any intentional act or negligence of Contractor, its agents, employees, officers, partners, or Subcontractors, without limitation; provided, however, that Contractor shall not indemnify for that portion of any claim, loss, or damage arising hereunder due to the sole fault of the Department. Contractor is solely responsible for all payments owed to any Subcontractor arising from Contractor's performance under the contract and will hold the Department harmless from any such payments owed to the subcontractor.

    19.3. The parties agree that if there are any limitations of Contractor's liability, including a limitation of liability clause for anyone for whom Contractor is responsible, such limitations of liability will not apply to injuries to persons, including death, or to damages to property.

20. **INDEMNIFICATION RELATING TO INTELLECTUAL PROPERTY**: Contractor shall indemnify and hold the Department and the State of Utah harmless from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities, and costs in any action or claim brought against the Department or the State of Utah for infringement of a third party's copyright, trademark, trade secret, or other proprietary right. The parties agree that if there are any limitations of Contractor's liability, such limitations of liability will not apply to this section.

21. DEBARMENT: Contractor certifies it is not presently nor has ever been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in the Contract, by any governmental department or agency, whether international, national, state, or local, and certifies it is in compliance with Utah Code Ann. § 63G-6a-904 *et seq.* and OMB guidelines at 2 C.F.R. § 180 which implement Executive Order Nos. 12549 and 12689. Contractor must notify Department within thirty (30) days if debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in any contract by any governmental entity during the Contract.

22. TERMINATION AND DEFAULT:

22.1. The Department may terminate the Contract without cause, upon thirty (30) days written notice to Contractor.

22.2. The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for the Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate the contract upon thirty (30) days' notice to Contractor. If funding to the Department is reduced due to an order by the Legislature or the governor, or is required by federal or state law, the Department may terminate the Contract or proportionately reduce the services and goods due and the amount due from the Department upon thirty (30) days written notice to Contractor. If the specific funding source for the subject matter of the Contract is reduced, the Department may terminate the Contract or proportionately reduce the services and goods due and the amount due from the Department upon thirty (30) days written notice to Contractor.

22.3. Each party may terminate the Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of the Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within ten (10) days of the notice. If the default is not cured within the ten (10) days, the party giving notice may terminate the Contract forty (40) days from the date of the initial notice of default or at a later date specified in the notice.

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

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

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

22.7. If the Department terminates the Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace Contractor's obligations. If the

termination is due to Contractor's failure to perform, and the Department procures replacement goods or services, Contractor agrees to pay the excess costs associated with obtaining the replacement goods or services.

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

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

22.10. Any of the following events will constitute cause for the Department to declare Contractor in default of this Contract: (i) Contractor's non-performance of its contractual requirements and obligations under this Contract; or (ii) Contractor's material breach of any term or condition of this Contract. The Department may issue a written notice of default providing a ten (10) day period in which Contractor will have an opportunity to cure. Time allowed for cure will not diminish or eliminate Contractor's liability for damages. If the default remains after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: (i) exercise any remedy provided by law or equity; (ii) terminate this Contract; (iii) impose liquidated damages, if liquidated damages are listed in this Contract; (iv) debar/suspend Contractor from receiving future contracts from the Department or the State of Utah; or (v) demand a full refund of any payment that the Department has made to Contractor under this Contract for Goods that do not conform to this Contract.

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

23. REVIEWS: The Department reserves the right to perform plan checks, plan reviews, other reviews, and/or comment upon the Goods and Services of Contractor. Such reviews do not waive the requirement of Contractor to meet all of the terms and conditions of the Contract.

24. PERFORMANCE EVALUATION: The Department may conduct a performance evaluation of Contractor's Services, including Contractor's Subcontractors. Results of any evaluation may be made available to Contractor upon request.

25. PUBLIC INFORMATION: Contractor agrees that the Contract, related purchase orders, related pricing documents, and invoices will be public documents and may be available for public and private distribution in accordance with the State of Utah's Government Records Access and Management Act (GRAMA). Contractor gives the Department and the State of Utah permission to make copies of the Contract, related sales orders, related pricing documents, and invoices in accordance with GRAMA. Except for sections identified in writing by Contractor and expressly approved by the State of Utah Division of Purchasing and General Services, Contractor also agrees that Contractor's Proposal to the Solicitation will be a public document, and copies may be given to the public as permitted under GRAMA. The Department and the State of Utah are not obligated to inform Contractor of any GRAMA requests for disclosure of the Contract, related purchase orders, related pricing documents, or invoices.

26. PUBLICITY: Contractor shall submit to the Department for written approval all advertising and publicity matters relating to this Contract. It is within the Department's sole discretion whether to provide approval, which must be done in writing.

27. **INFORMATION OWNERSHIP**: Except for confidential medical records held by direct care providers, the Department shall own exclusive title to all information gathered, reports developed, and conclusions reached in performance of the Contract. Contractor shall not use or disclose, except in meeting its obligations under the Contract, information gathered, reports developed, or conclusions reached in performance of the Contract without prior written consent from the Department. The Department shall own and retain unlimited rights to use, disclose, or duplicate all information and data (copyrighted or otherwise) developed, derived, documented, stored, or furnished by Contractor under the Contract. Contractor, and any Subcontractors under its control, expressly agrees not to use confidential federal, state, or local government information without prior written consent from the Department.

28. **INFORMATION PRACTICES**: Contractor shall establish, maintain, and practice information procedures and controls that comply with federal and state law including, as applicable, Utah Code § 26-1-1 *et seq* and the privacy and security standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") & the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"). Contractor shall receive or request from the Department only information about an individual that is necessary to Contractor's performance of its duties and functions. Contractor shall use the information only for purposes of the Contract. The Department shall inform Contractor of any non-public designation of any information it provides to Contractor.

29. **SECURE PROTECTION AND HANDLING OF STATE DATA:**

29.1. If Contractor is given State Data as part of this Contract, the protection of State Data shall be an integral part of the business activities of Contractor to ensure that there is no inappropriate or unauthorized use of State Data. To the extent that Contractor is given State Data, Contractor shall safeguard the confidentiality, integrity, and availability of the State Data. Contractor agrees to not to copy, reproduce, sell, assign, license, market, transfer, or otherwise dispose of, give, or disclose such information to third parties or use such information for any purpose whatsoever other than the performance of the Contract. The improper use or disclosure of confidential information is strictly prohibited.

29.2. Any and all transmission or exchange of State Data shall take place via secure means. Contractor shall create, store, and maintain any State Data on secure or encrypted computing devices or any portable storage mediums. Contractor agrees to protect and maintain the security of State Data with security measures including, but are not limited to, maintaining secure environments that are patched and up to date with all appropriate security updates as designated, network firewall provisioning, and intrusion detection. Contractor agrees that any computing device or portable medium that has access to the Department's network or stores any non-public State Data is equipped with strong and secure password protection.

29.3. Contractor shall: (a) limit disclosure of any State Data to Authorized Person who have a need to know such information in connection with the current or contemplated business relationship between the parties to which the Contract relates, and only for that purpose; (b) advise its Authorized Persons of the proprietary nature of the State Data and of the obligations set forth in the Contract and require such Authorized Persons to keep the State Data confidential; (c) keep all State Data strictly confidential by using a reasonable degree of care, but not less than the degree of care used by it in safeguarding its own confidential information; and (d) not disclose any State Data received by it to any third parties, except as permitted by the Contract or otherwise agreed to in writing by the Department.

29.4. Contractor will promptly notify the Department of any misuse or misappropriation of State Data that comes to Contractor's attention. Contractor shall be responsible for any breach of this duty of confidentiality by any of their officers, agents, subcontractors at any tier, and any of their respective representatives, including any required remedies and/or notifications under applicable law (Utah Code Ann. §§ 13-44-101 through 301). This duty of confidentiality shall be ongoing and survive the term of the Contract. Notwithstanding the foregoing, if there is a

discrepancy between a signed business associate agreement and this provision, the business associate agreement language shall take precedence.

30. **OWNERSHIP, PROTECTION, AND RETURN OF DOCUMENTS AND DATA UPON CONTRACT TERMINATION OR COMPLETION**: All documents and data pertaining to work required by the Contract will be the property of the Department, and must be returned to the Department or disposed of within thirty (30) days after termination or expiration of the Contract, regardless of the reason for contract termination, and without restriction or limitation to their future use. If such return or destruction is not feasible, Contractor shall notify the Department. Contractor shall extend any protections, limitation, and restrictions of the Contract to any information retained after the termination of the Agreement and shall limit further uses and disclosures to those purposes that make the return or destruction of the data infeasible. Any disposal of State Data must be disposed of in such a manner that it cannot be recovered or recreated. Notwithstanding the foregoing, if there is a discrepancy between a signed business associate agreement and this provision, the business associate agreement language shall take precedence.

31. **OWNERSHIP IN INTELLECTUAL PROPERTY:** The Department and Contractor agree that each has no right, title, interest, proprietary or otherwise in the intellectual property owned or licensed by the other, unless otherwise agreed upon by the parties in writing. All deliverables, documents, records, programs, data, articles, memoranda, and other materials not developed or licensed by Contractor prior to the execution of this Contract, but specifically created or manufactured under this Contract shall be considered work made for hire, and Contractor shall transfer any ownership claim to the Department.

32. **SOFTWARE OWNERSHIP:** If Contractor develops or pays to have developed computer software exclusively with funds or proceeds from the Contract to perform its obligations under the Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under the Contract, the computer software shall be exclusively owned by or licensed to the Department. If Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from the Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under the Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to Contractor a nontransferable, nonexclusive license to use the software in the performance of the Contract. In the case of software licensed to the Department, the Department grants to Contractor permission to use the software in the performance of the Contract. This license or permission, as the case may be, terminates when Contractor has completed its work under the Contract. If Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by the Contract, then to the extent allowed by the license agreement between Contractor and the owner of the software, Contractor grants to the Department a continuing, nonexclusive license for either the Department or a different contractor to use the software in order to perform work substantially identical to the work performed by Contractor under the Contract. If Contractor cannot grant the license as required by this section, then Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under the contract in such a manner to allow the Department or another contractor to continue the work performed by contractor under the Contract.

33. **WARRANTY OF GOODS**:

    33.1. Contractor warrants, represents and conveys full ownership and clear title, free of all liens and encumbrances, to the Goods delivered to the Department under the Contract. If not more specifically set out in the contract, Contractor warrants for a period of one (1) year that: (i) the Goods perform according to all specific claims that Contractor has made; (ii) the Goods are suitable for the ordinary purposes for which such Goods are used; (iii) the Goods are suitable for any special purposes identified by the Department; (iv) the Goods are designed and manufactured in a commercially reasonable manner; (v) the Goods are manufactured and in all other respects create no harm to persons or property; and (vi) the Goods are free of

defects or unusual problems about which the Department has not been warned. Unless otherwise specified, all Goods provided shall be new and unused of the latest model or design.

33.2. Notwithstanding the foregoing, any software portions of the Goods that Contractor licenses, contracts, or sells to the Department under the Contract, Contractor agrees that for a period of ninety (90) days from the date of the Department's acceptance that the warranties listed in 33.1 apply to the software portions.

33.3. Contractor warrants and represents that all services shall be performed in conformity with the requirements of the Contract by qualified personnel in accordance with generally recognized standards and conform to contract requirements.

34. WARRANTY REMEDIES: Contractor acknowledges that all warranties granted to the Department by the Uniform Commercial Code of the State of Utah apply to the Contract. Product liability disclaimers and/or warranty disclaimers from Contractor are not applicable to the Contract. For any goods or service that the Department determines does not conform with this warranty, the Department may arrange to have the item repaired or replaced, or the service performed either by Contractor or by a third party at the Department's option, at Contractor's expense. If any item or services does not conform to this warranty, Contractor shall refund the full amount of any payments made. Nothing in this warranty will be construed to limit any rights or remedies the Department may otherwise have under the contract.

35. UPDATES AND UPGRADES: Contractor grants to the Department a non-exclusive, non-transferable license to use upgrades and updates provided by Contractor during the term of the Contract. Such upgrades and updates are subject to the terms of the Contract. The Department shall download, distribute, and install all updates as released by Contractor during the length of the Contract, and Contractor strongly suggests that the Department also downloads, distributes, and installs all upgrades as released by Contractor during the length of the Contract. Contractor shall use commercially reasonable efforts to provide the Department with work-around solutions or patches to reported software problems that may affect the Department's use of the software during the length of the Contract.

36. TECHNICAL SUPPORT AND MAINTENANCE: If technical support and maintenance is a part of the Goods that Contractor provides under the Contract, Contractor will use commercially reasonable efforts to respond to the Department in a reasonable time when the Department makes technical support or maintenance requests regarding the Goods.

37. EQUIPMENT PURCHASE: Contractor shall obtain prior written Department approval before purchasing any equipment, as defined in the Uniform Guidance, with contract funds.

38. DELIVERY: Unless otherwise specified in the Contract, all deliveries will be F.O.B. destination with all transportation and handling charges paid by Contractor. Responsibility and liability for loss or damage will remain with Contractor until final inspection and acceptance, when responsibility will pass to the Department, except as to latent defects, fraud and Contractor's warranty obligations. The parties shall ship all orders promptly in accordance with the delivery schedule. Contractor shall submit promptly invoices (within thirty (30) days of shipment or delivery of services) to the Department. The parties shall list the state contract number on all invoices, freight tickets, and correspondence related to the Contract. The prices paid by the Department shall be the prices listed in the Contract, unless Contractor offers a prompt payment discount within its proposal or on its invoice. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

39. ACCEPTANCE AND REJECTION: The Department shall have thirty (30) days after the performance of the Services to perform an inspection of the Services to determine whether the Services conform to the standards specified in the Solicitation and this Contract prior to acceptance of the Services by the Department. If Contractor delivers nonconforming Services, the Department may, at its option and at Contractor's expense: (i) return the Services for a full refund; (ii) require Contractor to promptly correct or re-perform the nonconforming Services subject to the terms of this Contract; or (iii) obtain

Attachment B – Special Provisions

Article 1 Introductory Provisions

1.1 Parties

(A) This contract is between the State of Utah, acting by and through its Department of Health hereinafter referred to as "DOH" or "Department" and University of Utah Health Plans**,** hereinafter referred to as "Contractor." Together, the Department and Contractor shall be referred to as the "Parties."

(B) In compliance with 42 CFR 438.602(i), the Contractor agrees that for the duration of this Contract, the Contractor shall not be located outside of the United States.

1.2 Notices

Any notices that are permitted or required under this Contract shall be in writing and shall be transmitted through either:

(a) Certified or registered United States mail, return receipt requested;
(b) Personal delivery;
(c) Expedited Delivery Service.

Such Notices shall be addressed as follows:

Department (If by Mail):

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

Department (If in Person):

Utah Department of Health
Medicaid and Health Financing
Director, Bureau of Managed Health Care
288 North 1460 West
Salt Lake City, UT 84114

Contractor:

University of Utah Health Plans
6053 S Fashion Square Dr, Ste# 110
Murray, UT 84107

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

1.3 Service Area

1.3.1 Service Area, Generally

(A) The Service Area is the specific geographic area within which the Medicaid Eligible Individual must reside to enroll in the Contractor's Health Plan. The Service Area for this Contract is all counties within the State of Utah.

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

1.3.2 Reduction of Service Area

If the Contractor reduces the Service Area it must notify the Department 90 days prior to the reduction and notify Enrollees 60 days prior to the reduction. Notice to Enrollees must be approved of in advance by the Department.

1.3.3 Service Area Expansion

With written approval of the Department, the Contractor may expand into additional Service Areas. To request expansion into an additional Service Area, the Contractor must make a written request to the Department and provide any evidence requested by the Department that demonstrates the Contractor's ability to expand into the additional Service Area.

1.3.4 Residency in Service Area

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

1.3.5 Mandatory/Voluntary Enrollment Service Areas

Medicaid Eligible Individuals residing in Salt Lake, Weber, Davis, Utah, Box Elder, Iron, Rich, Tooele, Washington, Cache, Morgan, Summit and Wasatch counties are mandatorily enrolled in a Managed Care Organization. Medicaid Eligible Individuals residing in all other counties may voluntarily enroll in a Managed Care Organization operating in their county.

ARTICLE 2: Definitions

2.1 Contract Definitions

2.1.1 Definitions

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

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

Abuse Potential Medications means drugs which are included in the Federal DEA controlled substance schedules C-II through C-V.

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

Adverse Benefit Determination means:

1. the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a Covered Service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service;
4. the failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times;
5. the failure of the Contractor to act within the time frames established for resolution and notification of Grievances and Appeals;
6. for a resident of a rural area with only one MCO, the denial of an Enrollee's right to exercise his or her right to obtain services outside the network; or
7. the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

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

Aggrieved Person means an Aggrieved Person as defined by Utah Administrative Code R410-14-2.

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

Balance Bill means the practice of billing patients for charges that exceed the amount that the Contractor will pay.

CAHPS means Consumer Assessment of Health Plans and Systems survey.

Behavioral Management Services means structured services designed to serve individuals with emotional, behavioral, and neurobiological or substance abuse problems of such severity that appropriate functioning in the home, school, or community requires highly structured behavioral intervention.

BMHC means the Bureau of Managed Health Care, Division of Medicaid and Health Financing, Utah Department of Health.

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

Capitation Payment means the payment the Department makes periodically to the Contractor on behalf of each Enrollee for the provision of Covered Services under the Contract and based on the actuarially sound Capitation Rate. The Department makes the payment regardless of whether the Enrollee receives services during the period covered by the payment.

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

CHEC Enrollee means an Enrollee who is eligible to receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services in accordance with 42 CFR Part 441, Subpart B.

CHEC or Child Health Evaluation and Care means Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B.

Child with Special Health Care Needs means a child under 21 years of age who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with Section 1932(a) (2) (A) of the Social Security Act, 42 U.S.C.1396u-2(a) (2) (A):

1. is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act);

2. is in Foster Care or other out-of-home placement;

3. is receiving Foster Care or adoption assistance; or

4. is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in Section 501(a) (1)(D) of Title V of the Social Security Act.

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

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

CMS means the Centers for Medicare and Medicaid Services, the federal Medicaid agency, within the Department of Health and Human Services.

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

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

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

Controlled Substance Database means the Controlled Substance Database maintained by the Utah Department of Commerce in accordance with Utah Code Ann. §58-37f-101, *et seq.*

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

Covered Services means services identified in Attachment C and Attachment D of this Contract which the Contractor has agreed to provide and pay for under the terms of this Contract.

Coverage and Reimbursement Code Look-Up Tool: means the Department's coverage and reimbursement code database located on the Department's official website.

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

DOPL means the Utah Division of Occupational and Professional Licensing.

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

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

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

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

Enrollee means any Medicaid Eligible Individual whose name appears on the Department's Eligibility Transmission as enrolled in the Contractor's Health Plan.

Enrollee Encounter Data means the information relating to the receipt of any item(s) or service(s) by an Enrollee under this Contract that is subject to the requirements of 42 CFR 438.242 and 42 CFR 483.818.

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

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

Excluded Parties List System or **EPLS** means the electronic version of the Lists of Parties Excluded from Federal Procurement and Non-procurement Programs (List) that identifies those individual and firms excluded from receiving Federal contracts or Federally-approved subcontracts and from certain types of Federal financial and non-financial assistance and benefits. The EPLS website is located at http://epls.gov.

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

External Quality Review or **EQR** means the analysis and evaluation of information on quality, timeliness, and access to the health care services that a Health Plan, or its Providers, furnished to its Enrollees.

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

Family Member means all Medicaid Eligible Individuals who are members of the same family living at home.

Federal Financial Participation or **FFP** means, in accordance with 42 CFR 400.203, the Federal Government's share of a state's expenditures under the Medicaid program and is determined by comparing a state's per capita income to the national average.

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

FFS means the Fee For Service Utah Medicaid Program.

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

Foster Care or **Children in Foster Care** means children and youth under the statutory responsibility of the Utah Department of Human Services identified as such in eREP.

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

Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

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

Health Care-Acquired Condition or **HAC** means a condition occurring in any inpatient hospital setting, defined as a HAC by the Secretary of Health and Human Services under Section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(D)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis(DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Health Insuring Organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries (1) through payments to, or arrangements with, providers; (2) under a Comprehensive Risk Contract with the State; and (3) meets the following criteria: (i) first became operational prior to January 1, 1986; or (ii) is described in

section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Health Insurer Fee means the annual fee the Contractor is required to pay pursuant to Section 9010 of the Patient Protection and Affordable Care Act

Health Plan means a Managed Care Organization under contract with the Department to provide specified physical health care services to a specific group of Medicaid Eligible Individuals.

HEDIS means Healthcare Effectiveness Data and Information Set maintained by NCQA.

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

ICF/ID means an intermediate care facility for individuals with intellectual disabilities.

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

Indian Health Care Provider means a health care program, operated by Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined by 25 USC §1603.

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

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

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

Managed Care Entity or **MCE** means MCOs, PIHPs, PAHPs, PCCMs, and HIOs. The Contractor is an MCO.

Managed Care Organization or **MCO** means an entity that has, or is seeking to qualify for, a Comprehensive Risk Contract, and that is – (1) A Federally qualified HMO that meets the Advance Directives requirements of 42 CFR 489, Subpart I; or (2) Any public or private entity that meets the Advance Directives requirement of42 CFR 489, Subpart I and is determined by the Secretary of the U.S. Department of Health and Human Services to also meet the following conditions: (i) Makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity and (ii) meets the solvency standards of 42 CFR 438.116.

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

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

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

Marketing Materials means materials that are produced in any medium, by or on behalf of the Contractor, its employees, affiliated Providers, agents or subcontractors to a potential enrollee that can reasonably be intended to market to potential enrollees.

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

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

Medically Necessary or Medical Necessity means Medically Necessary Service as defined by Utah Administrative Code R414-1-2-

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

MLR means Medical Loss Ratio as described in Article 12.5.

NCQA means the National Committee for Quality Assurance.

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

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

Non-Traditional Enrollee means an Enrollee who qualifies for the reduced benefit plan provided in the 1115 Demonstration for the Primary Care Network of Utah demonstration waiver.

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

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

NQF means the National Quality Forum.

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

OHCS means the Utah Department of Health's Office of Health Care Statistics.

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

1. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare;

2. Any Medicare intermediary or carrier: and

3. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Social Security Act.

Other Provider-Preventable Condition means a condition occurring in a health care setting that meets the following criteria:

1. Is identified in the State Plan.

2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

3. Has a negative consequence for the Enrollee.

4. Is auditable.

5. Includes, at minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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

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

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

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

1. Has an ownership interest totaling 5 percent or more in the Contractor;

2. Has an indirect ownership interest equal to 5 percent or more in the Contractor;

3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in the Contractor;

4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the property or assets of the Contractor;

5. Is an officer or director of the Contractor including the Contractor's Board of

Directors' members, if applicable; or

6. Is a partner in the Contractor that is organized as a partnership.

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

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

Potential Enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Health Plan.

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

Prepaid Inpatient Health Plan or **PIHP** means an entity that provides medical services to Enrollees under contract with the Department, and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of inpatient hospital or institutional services for its Enrollees; and does not have a Comprehensive Risk Contract.

Prepaid Mental Health Plan or **PMHP** means a mental health and/or substance use disorder Managed Care Organization operating under the authority of the Department's mental health freedom-of-choice waiver.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

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

Primary Care Provider or **PCP** means a health care provider the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. The Contractor may allow other specialists to be PCPs, when appropriate. PCPs are responsible for delivering Primary Care services, coordinating and managing Enrollees' overall health, and authorizing referrals for

other necessary care.

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

Provider Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition or an Other Provider-Preventable condition.

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

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

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

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

Restriction Program means the program mandated by 42 CFR 431.54(e) for Medicaid Eligible Individuals who over-utilize Medicaid services.

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

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

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

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

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

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

Subcontract means any written agreement between the Contractor and another party to fulfill the requirements of this Contract. However, such term does not include insurance purchased by the Contractor to limit its loss with respect to an individual Enrollee.

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

Suspended means, for purposes of Article 6 of this Contract that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

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

TTY/TTD means a teletype writer and telecommunications device for the deaf.

Third Party Liability or TPL means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan.

Waste means overutilization of resources or inappropriate payment.

ARTICLE 3: Marketing and Enrollment

3.1 Marketing Activities

3.1.1 Marketing, Generally

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

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

3.1.2 Prohibited Marketing Activities

(A) Contractor, its employees, Network Providers, agents, or subcontractors are prohibited from:

(1) Directly or indirectly, conducting door-to-door, telephonic, or other "Cold Call" Marketing activities;

(2) Influencing a Potential Enrollee's enrollment in conjunction with the sale or offering of any private insurance; and

(3) Distributing any materials that include statements that will be considered inaccurate, false, or misleading. Such statements can include that the Potential Enrollee must enroll with the Contractor in order to obtain or not to lose benefits; or that the Contractor has been endorsed by CMS, the Federal or State government, or similar entity.

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

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

3.2.2 Department Approval

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

3.2.3 Specify Methods

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

3.2.4 Distribution of Marketing Materials

The Contractor shall distribute Marketing materials in all Service Areas the Contractor serves.

3.2.5 Marketing Activities Prohibited

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

3.3 Enrollment Process

3.3.1 Enrollee Choice

(A) The Department shall determine eligibility for Enrollment and will offer Potential Enrollees a choice among all health plans available in the Service Area.

(B) The Department will inform Potential Enrollees of Medicaid benefits.

(C) The Medicaid Eligible Individual's intent to enroll is established when the applicant selects the Contractor, either verbally or by signing a choice of health care delivery form or equivalent. If the Enrollee does not choose a Health Plan, the Department may automatically assign the Enrollee to a health plan based on a methodology approved by CMS. This initiates the action to send an advance notification to the Contractor.

(D) Medicaid enrollees made eligible for a retroactive period prior to the current month are not eligible for Contractor enrollment during the retroactive period.

3.3.2 Period of Enrollment

(A) Each Enrollee will be enrolled for either the period of this Contract, the period of Medicaid eligibility, or until such person disenrolls or is disenrolled, whichever is earlier.

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

(C) Each enrollee shall be automatically re-enrolled at the end of each month unless the Enrollee notifies the Department's Health Program Representatives of an intent not to re-enroll in the Health Plan prior to the benefit issuance date and the reason for not re-enrolling meets the Department's criteria found in Article 3.7 of this Contract.

3.3.3 Open Enrollment

The Contractor shall have a continuous open enrollment period for new Enrollees. The Department shall certify, and the Contractor agrees to accept, individuals who are eligible to be enrolled in the Health Plan. Contractor shall accept Enrollees in the order in which they apply.

3.3.4 Prohibition Against Conditions on Enrollment

(A) Contractor must accept eligible Enrollees in the order in which they apply without restrictions unless such restriction is authorized by the Department.

(B) Contractor and Department may not pre-screen or select Potential Enrollees on the basis of pre-existing health problems.

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

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

3.3.5 Independent Enrollment

(A) Each Medicaid Eligible Individual can be enrolled or disenrolled from the Health Plan independent of any other Family Member's enrollment or disenrollment.

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

3.4 Eligibility Transmission

3.4.1 Eligibility Transmission, Generally

(A) The Department shall provide to the Contractor an Eligibility Transmission which is an electronic file that includes data on individuals that the Department certifies as being Medicaid Eligible and who have been enrolled in Contractor's Health Plan. The Eligibility Transmission will include new Enrollees, reinstated Enrollees, retroactive Enrollees, terminated Enrollees and Enrollees whose eligibility information results in a change to a critical field.

(B) Critical Fields found in the Eligibility Transmission shall include: Enrollee's case number, case name, eREP identification number, name, date of birth, date of death, social security number, gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, (including those for Indians) eligibility start date, third party liability coverage, county, address, phone number, and if applicable, the Enrollee's Provider under the Restriction Program.

(C) The Eligibility Transmission shall be designated as the "834 File" and shall be in accordance with the Utah Health Information Network ("UHIN") standard.

(D) The appearance of an individual's name on the 834 File, other than a deleted Enrollee, shall be evidence to the Contractor that the Department has determined that the individual is enrolled in the Health Plan and qualifies for Medical Assistance under Tile XIX of the Social Security Act.

(E) In addition to the monthly transmission of eligibility files, the Department shall send daily transmissions to report changes to the Contractor.

3.4.2 Eligibility Transmission, Specific Types of Enrollees

(A) For purposes of the Eligibility Transmission the following designations apply:

(1) New Enrollees shall be enrolled in the Health Plan until they have been terminated from the Health Plan. New Enrollees will not appear on future eligibility transmissions unless there is a change in a critical field.

(2) Newborn Retroactive Enrollees are newborns whose mothers are enrolled with the Health Plan on the newborn's date of birth. A Newborn Retroactive Enrollee is deemed to be enrolled in the same plan as the mother, retroactively, to the first day of the newborn's birth month.

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

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

3.4.3 Eligibility File, Contractor Responsibilities

(A) The Contractor shall be responsible for ensuring that it is using the most recent 834 file when processing claims.

(B) The Contractor shall follow the policies and procedures found in the Department's 834 Eligibility Transmission Manual, the HIPAA 834 Best Practices Manual, and any amendments to these documents.

3.5 Member Orientation

3.5.1 Initial Contact—General Orientation

(A) The Contractor shall make a good faith effort to ensure that each Enrollee or Enrollee's family or guardian receives the Contractor's Member Handbook.

(B) The Contractor's representative shall make a good faith effort to make an initial contact with the Enrollee within 10 working days after the Contractor has been notified through the Eligibility Transmission of the Enrollee's enrollment in Contractor's Health Plan. Contractor shall maintain written or electronic records of such initial contact.

(1) If the Contractor's representative cannot contact the Enrollee within 10 working days or at all, the Contractor's representative shall document its efforts to contact the Enrollee.

(2) The initial contact shall be in person or by telephone and shall inform the Enrollee of the Contractor's rules and policies. The initial contact may also be in writing but only if reasonable attempts have been made to contact the Enrollee in person and by telephone and those attempts have been unsuccessful.

(C) The Contractor shall ensure that Enrollees are provided interpreters, Telecommunication Device for the Deaf (TDD), and other auxiliary aids to ensure that Enrollees understand their rights and responsibilities.

(D) During the initial contact, the Contractor's representative shall provide, at minimum, the following information to the Enrollee or Potential Enrollee:

(1) Specific written and oral instructions on the use of the Contractor's Covered Services and procedures;

(2) Availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Non-Network Providers;

(3) the Rights and Responsibilities of the Enrollee under the Health Plan, including the right to file a Grievance and how to file a Grievance;

(4) the right to terminate enrollment with the Health Plan; and

(5) encouragement to make a medical appointment with a Provider.

3.5.2 Initial Contact--Identification of Enrollees with Special Health Care Needs

(A) The Contractor shall establish a policy which shall be used by Contractor's representative during the initial contact to identify children and adults with Special Health Care Needs, and to identify persons who need LTSS, to the extent the LTSS are Covered Services under this Contract.

(B) During the initial contact, the Contractor's representative shall clearly describe to each Enrollee the process for requesting specialist care.

(C) When an Enrollee is identified as having Special Health Care Needs, the Contractor's representative shall forward this information to a Contractor's individual with knowledge of coordination of care, case management services, and other services necessary for such Enrollees. The Contractor's individual with knowledge of coordination of care for Enrollees With Special

Health Care Needs shall make a good faith effort to contact such Enrollees within ten working days after identification to begin coordination of health care needs, if necessary.

(D) The Department's Health Program Representatives will forward information, including risk assessments, that identify Enrollees With Special Health Care Needs and limited language proficiency needs to the Contractor. Such information will coincide with the daily Eligibility Transmission whenever possible.

3.5.3 Enrollees Receiving Out-of-Plan Care Prior to Orientation

(A) If the Enrollee receives Covered Services by a Non-Network Provider after the first day of the month in which the enrollee's enrollment became effective, the Contractor and Department shall determine if an Enrollee could have reasonably known that the Provider was a Non-Network Provider. The Enrollee will be deemed to not reasonably have known that the Provider was a Non-Network Provider if:

> (1) A Contractor orientation, either in person, or by telephone (or by writing as allowed in the terms of this contract), has not taken place prior to the Enrollee receiving such services;
>
> (2) The Enrollee had been enrolled in the plan in the previous three months and did not receive an orientation; or
>
> (3) The Enrollee did not receive out-of-network information through the Department either through the Health Program Representative, Medicaid Member Guide, or Health Plan comparison chart.

(B) If the Department determines that an Enrollee could not have reasonably known that a Provider was a Non-Network Provider based on the above criteria, the Contractor shall pay for the services rendered. In cases of retroactive eligibility if the Department determines that the Department did not provide eligibility information on or prior to the first day of the month in which the Medicaid Eligible Individual's enrollment became effective, and the Enrollee could not reasonably have known that the Provider was a Non-Network Provider based on the above criteria, the Department is responsible for the payment of the services rendered unless agreed upon otherwise.

3.6 Enrollee Information

3.6.1 Enrollee Information Requirements—Generally

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

(B) Once a year, the Contractor shall notify all Enrollees of their right to request and obtain the Contractor's member handbook.

(C) The Enrollee information required under this Article 3.6 may not be provided electronically unless:

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

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

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

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

(5) the Contractor notifies the Enrollee that the information is available in paper form within five business days.

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

(E) The Contractor shall make auxiliary aids and services available upon request of the Potential Enrollee or Enrollee at no cost.

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

(G) The Contractor shall notify its Enrollees that:

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

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

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

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

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

(J) The Contractor shall use Enrollee notices developed by the Department. The Contractor shall ensure that the Enrollee notices developed by the Department are in use by July 1, 2018.

3.6.2 Enrollee Information Requirements—Prevalent Language

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

(B) The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, Enrollee handbooks, Appeal and Grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular Service Area. The Contractor shall ensure that its written materials meet this requirement by July 1, 2018. .

3.6.3 Enrollee Information Requirements—Written Materials

(A) In accordance with 42 CFR 438.10(d)(3), the Contractor's written materials shall:

(1) be made available in alternative formats upon request of the Potential Enrollee or Enrollee at no cost;

(2) include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided; and

(3) include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MCP's member/customer service unit.

(B) The Contractor shall provide all written materials for Potential Enrollees and Enrollees in an easily understood language and format.

(C) The Contractor shall:

(1) provide all written materials for potential Enrollees and Enrollees in a font size no smaller than 12 point;

(2) make written materials for potential Enrollees and Enrollees available in alternative formats in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency;

(3) make written materials for potential Enrollees and Enrollees available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Enrollees or potential Enrollees with disabilities or limited English proficiency; and

(4) include on all written materials a large print tagline and information on how to request auxiliary aids and services, including materials in alternative formats.

(D) The Contractor shall ensure that its written materials meet this requirement by July 1, 2018.

3.6.4 Enrollee Handbook

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

(B) By July 1, 2018, the Contractor shall use the model Enrollee handbook developed by the Department. The Department shall designate which areas the Contractor is allowed to customize in the model Enrollee handbook.

(C) The Enrollee handbook shall contain information:

(1) that enables the Enrollee to understand how to effectively use the managed care program;

(2) on benefits provided by the Contractor. including information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled with the Contractor;

(3) on how and where to access any benefits provided by the Department, including EPSDT benefits delivered outside the Contractor, if any;

(4) regarding cost sharing on any benefits carved out of the Contract and provided by the Department;

(5) which details that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees that the service is not covered by the Contractor and how they can obtain

information from the Department about how to access those services;

(6) on the amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled; and

(7) procedures for obtaining benefits, including any requirements for service authorization and/or referrals for specialty care and for other benefits not furnished by the Enrollee's PCP;

(8) on the extent to which, and how, after-hours care is provided;

(9) on how emergency care is provided;

(10) regarding what constitutes an Emergency Medical Condition;

(11) regarding what constitutes an Emergency Service;

(12) that prior authorization is not required for Emergency Services;

(13) that the Enrollee has a right to use any hospital or other setting for emergency care;

(14) that includes cost sharing for services furnished by the Contractor, if any is imposed under the State Plan;

(15) on the Enrollee's freedom of choice among Network Providers;

(16) the extent to which, and how, Enrollees may obtain benefits including family planning services and supplies from Non-Network Providers;

(17) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider;

(18) that includes cost sharing for services furnished by the Contractor;

(19) on Enrollee rights and responsibilities, including the Enrollee's right to:

(i) receive information on beneficiary and plan information;

(ii) be treated with respect and with due consideration for his or her dignity and privacy;

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

(iv) participate in decisions regarding his or her health care, including the right to refuse treatment;

(v) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; and

(vi) request and receive a copy of their medical records and request that they be amended or corrected.

(20) on Enrollee rights and responsibilities, including the Enrollee's right to obtain available and accessible health care services covered under the Contract;

(21) on the process of selecting and changing the Enrollee's PCP;

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

(23) on the Enrollee's right to file Grievances and Appeals;

(24) on the requirements and timeframes for filing a Grievance or Appeal;

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

(26) on the availability of assistance in the filing process for Appeals;

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

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

(29) on how to exercise an Advance Directive;

(30) how to access auxiliary aids and services, including additional information in alternative formats or languages;

(31) regarding the toll-free telephone numbers for member services, medical management, and any other unit providing services directly to Enrollees;

(32) on how to report suspected Fraud or Abuse; and

(33) any other content required by the Department.

3.6.5 Enrollee Handbook Dissemination

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

(1) Mails a printed copy of the information to the Enrollee's mailing address;

(2) Provides the information by email after obtaining the Enrollee's agreement to receive the information by email;

(3) Posts the information on its website and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

(4) Provides the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3.6.6 Network Provider Directory

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

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

(2) Street addresses;

(3) Telephone numbers;

(4) Website URLs, as appropriate;

(5) Specialties, as appropriate;

(6) Whether Network Providers will accept new Enrollees;

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

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

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

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

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

(D) The Contractor shall comply with the Network Provider directory requirements found in this Article 3.6.6 by July 1, 2018.

3.6.7 Termination of Contracted Provider

The Contractor shall make a good faith effort to give written notice of termination of a Network Provider, within 15 days after receipt or issuance of the termination notice, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Network Provider.

3.6.8 Enrollee Handbook Review and Approval

(A) On July 1st of each year, the Contractor shall submit its enrollee handbook to the Department for review and approval. The Department shall notify the Contractor in writing of its approval or disapproval within thirty working days after receiving the enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon time frame, the Contractor may deem such materials approved by the Department.

(B) If there are changes to the content of the material in the enrollee handbook, the Contractor shall update the enrollee handbook and submit a draft to the Department for review and approval 45 days before distribution to Enrollees. The Department shall notify the Contractor in writing of its approval or disapproval within thirty working days after receiving the Enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon time frame, the Contractor may deem such materials approved by the Department.

3.6.9 Publication of Covered Medications

(A) The Contractor shall provide information in electronic or paper form about which generic and name brand medications are covered and what tier each medication is on.

(B) The Contractor shall provide formulary drug lists on the Contractor's website in a machine readable file and format as specified by the Secretary of Department of Health and Human Services.

3.6.10 Sales and Transactions

The Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the Department, or other agencies available to Enrollees upon reasonable request.

3.7 Disenrollment Initiated by Enrollees

3.7.1 Disenrollment by Enrollees in Rural Counties

Enrollees living in voluntary enrollment counties may disenroll from the Health Plan at any time and for any reason. The following limited disenrollment requirements apply only to Enrollees living in the mandatory enrollment counties.

3.7.2 Limited Disenrollment—Generally

The Department requires Enrollees to be enrolled with the same Health Plan for up to 12 months.

3.7.3 Limited Disenrollment—Without Cause

(A) Enrollees are permitted to transfer from one Health Plan to another without cause as follows:

(1) Within the first 90 days following the date of each enrollment period with the Health Plan;

(2) During the open enrollment period (which shall occur at least once a year or as otherwise defined by the Department); or

(3) When the Enrollee has been automatically re-enrolled after being disenrolled solely because the Enrollee lost Medicaid eligibility for a period of two months or less and the temporary loss of Medicaid eligibility caused the Enrollee to miss the annual disenrollment period.

3.7.4 Limited Disenrollment—With Cause

(A) Enrollees may request to transfer from one Health Plan to another at any time for the following reasons:

(1) The Enrollee moves out of the Health Plan's Service Area;

(2) The Enrollee needs related services to be performed at the same time and not all services are available within the network, and the Enrollee's Primary Care Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(3) Other reasons as determined by the Department, including but not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of access to Providers experienced in dealing with the enrollee's health care needs;

(4) Health Plan does not, because of moral or religious objections cover the service the Enrollee seeks;

(5) Enrollee becomes emancipated or is added to a different Medicaid case; or

(6) If the Health Plan makes changes to its network of Network Providers that interferes with an Enrollee's continuity of care with the Enrollee's Provider of choice.

3.7.5 Process for Requesting Health Plan Change

(A) The Enrollee may change Health Plans by submitting an oral or written request to the Department. The Enrollee must declare the Health Plan in which he or she wishes to enroll should the disenrollment be approved.

(B) If the Enrollee makes a request for disenrollment directly to the Contractor the Contractor shall forward the request for disenrollment to the Department.

(C) The Department shall review each disenrollment request from an Enrollee to determine if the request meets the criteria for cause, and if so, the Department shall allow the Enrollee to switch to another Health Plan. If the request does not meet criteria for cause, or if the concern is with a Provider and not the Health Plan, the Department shall deny the disenrollment request and inform the Enrollee of his or her rights to request a State fair hearing.

(D) If the Department fails to make a determination within ten calendar days after receiving the disenrollment request, the disenrollment is considered approved.

(E) The disenrollment shall be effective once the Department has been notified by the Enrollee and the disenrollment is indicated on the Eligibility transmission. The effective date of an approved disenrollment request shall be no later than the first day of the second month following the month in which the Enrollee filed the request.

3.7.6 Enrollees in an Inpatient Hospital Setting

(A) In the event that a new Enrollee is a patient in an inpatient hospital setting on the date the new Enrollee's name appears on the Contractor Eligibility Transmission, the obligation of the Contractor to provide Covered Services to such person shall commence following discharge (i.e., the financial obligation to pay for the inpatient hospital charges shall be the responsibility of the health plan or the Department who covered the enrollee at the time of admission). If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as terminated for any reason other than eligibility on the Contractor Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the Contractor shall remain financially responsible for

such care until discharge.

(B) The Department will retroactively retract enrollment and capitation payment(s) from the Contractor if the following requirements are met:

(1) the Enrollee is on FFS Medicaid at the time of admission to the inpatient hospital,

(2) the Enrollee is in an inpatient hospital or nursing home at the time the Enrollee's eligibility starts with the Contractor, and

(3) the Enrollee remains in the hospital or nursing home for longer than the first month enrollment with the plan.

3.8 Disenrollment Initiated by Contractor

3.8.1 Prohibition on Disenrollment for Adverse Change in Enrollee Health

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

3.8.2 Valid Reasons for Disenrollment

(A) The Contractor may initiate disenrollment of any Enrollee's participation in the Health Plan upon one or more of the following grounds:

(1) For reasons specifically identified in the Contractor's member handbook;

(2) When the Enrollee ceases to be eligible for medical assistance under the State Plan in accordance with 42 USC 1396, *et seq.* and as finally determined by the Department;

(3) Upon termination or expiration of the Contract;

(4) Death of the Enrollee;

(5) Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract;

(6) Violation of enrollment requirements developed by the Contractor and approved by the Department but only after the Contractor and/or the Enrollee has exhausted the Contractor's applicable internal Grievance procedure; or

(7) As allowed by Article 2.2 of Attachment C and Attachment D.

3.8.3 Approval by the Department Required

To initiate disenrollment of an Enrollee's participation with this Health Plan, the Contractor shall provide the Department with documentation justifying the proposed disenrollment. The Department shall approve or deny the disenrollment request within thirty days of receipt of the request. If the Department does not respond to the disenrollment request within 30 days, the disenrollment request is deemed approved.

3.8.4 Enrollee's Right to File an Appeal

If the Department approves the Contractor's disenrollment request, the Contractor shall give the Enrollee thirty days written notice of the proposed disenrollment, and shall notify the Enrollee of his or her opportunity to invoke the Contractor's Grievance and Appeals System. The Contractor shall give a copy of the written notice to the Department at the time the notice is sent to the Enrollee.

3.8.5 Refusal of Re-Enrollment

If a person is disenrolled because of a violation of responsibilities included in the Contractor's member handbook, the Contractor may refuse re-enrollment of that Enrollee.

3.8.6 Automatic Re-Enrollment

An Enrollee who is disenrolled from the Contractor's Health Plan solely because he or she loses Medicaid eligibility shall automatically be re-enrolled with the Contractor's Health Plan if the Enrollee regains Medicaid Eligibility within two months.

ARTICLE 4: BENEFITS

4.1 General Provisions

4.1.1 Basic Standards

(A) The Contractor shall provide to Enrollees, directly or through arrangements with Providers, all Medically Necessary Covered Services described in Attachment C and Attachment D as promptly and continuously as is consistent with generally accepted standards of medical practice.

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

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

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

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

(1) the services furnished can reasonably be expected to achieve their purpose; and

(2) the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports;

(3) family planning services are provided in a manner that protects and enables an Enrollee's freedom to choose the method of family planning to be used.

4.1.2 Covered Services

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

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

(1) services that address the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;

(2) the ability for an Enrollee to achieve age-appropriate growth and development;

(3) the ability for an Enrollee to attain, maintain, or regain functional capacity; and

(4) the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

4.2 Scope of Services

4.2.1 Scope of Covered Services

(A) Except as otherwise provided for cases of Emergency Services, the Contractor is responsible to arrange for all Covered Services listed in the Coverage and Reimbursement Look-Up Tool and the Department's Provider Manuals.

(B) The Contractor is responsible for payment of Emergency Services 24 hours a day, 7 days a

week whether the services were provided by a Network Provider or a Non-Network Provider and whether the service was provided inside or outside of the Contractor's Service Area.

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

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

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

4.2.2 Changes to Benefits

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

4.2.3 Court and Administrative Orders Regarding Benefits

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

4.2.4 Reconstructive Procedures and Least Costly Alternative

(A) The Contractor shall be responsible for providing reimbursement for a non-Covered Service when the non-Covered Service is:

(1) a reconstructive procedure following disfigurement caused by trauma or medically necessary surgery;

(2) a reconstructive procedure to correct serious functional impairments; or

(3) performing the otherwise non-Covered Service is more cost effective for the Medicaid Program than other alternatives.

(B) The Contractor shall have a process through which an Enrollee may request an otherwise non-Covered Service as described in Article 4.2.4(A).

(C) The Contractor shall inform Enrollees of their ability to obtain otherwise non-Covered Services as described in Article 4.2.4(A) and the process by which the Enrollee may request those services.

4.3 Covered Services—Emergency Services

4.3.1 Emergency Services Generally

(A) The Contractor is responsible for coverage and payment of Emergency Services as described by this Contract and by law.

(B) The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Network Provider or a Non-Network Provider.

(C) The Contractor may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

(D) The Contractor may not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within ten calendar days of presentation for Emergency Services.

(E) The Contractor shall inform Enrollees that access to Emergency Services is not restricted and that if an Enrollee experiences a medical emergency, he or she may obtain services from a Non-Network Provider without penalty.

(F) The Contractor shall pay Non-Nework Providers for Emergency Services no more than the amount that would have been paid if the service had been provided under the Department's Fee-For-Service Medicaid program.

4.3.2 Payment Liability for Emergency Services

(A) An Enrollee who has had an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

(C) If there is a disagreement between a Provider and the Contractor concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an

unstabilized transfer outweighs the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one if its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

(D) In the event an Enrollee presents to an Emergency Room with both a physical health and mental health diagnosis, and the Enrollee requires medical stabilization, the Contractor shall pay for the facility charge and any ancillary services for the entire Emergency Room visit.

4.3.3 Payment Liability in the Absence of a Clinical Emergency

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

4.3.4 Payment Liability for Referrals

The Contractor may not deny payment for treatment obtained by an Enrollee when a representative of the Contractor, including the Enrollee's Primary Care Provider, instructs the Enrollee to seek emergency care.

4.4 Covered Services—Post Stabilization Care

4.4.1 Post Stabilization Care Generally

The Contractor shall cover and pay for Post-Stabilization Care in accordance with the guidelines found in 42 CFR 422.113(c). Generally, Post-Stabilization Care Services begin when an Enrollee is admitted for an inpatient hospital stay after the Enrollee has received Emergency Services. However, in situations where a Provider demonstrates that the Enrollee received Emergency Services related to an Emergency Medical Condition during the inpatient admission, the Contractor shall reimburse the Provider in accordance with the payment provisions governing Emergency Services outlined in Article 4.3.

4.4.2 Pre-Approved Post-Stabilization Care Services

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

4.4.3 Other Contractor-Liable Post-Stabilization Care Services

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

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

(1) The Contractor does not respond to a request for pre-approval within one hour of the request;

(2) The Contractor cannot be contacted; or

(3) The Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with the care of the Enrollee until a Contractor physician is reached, or one of the following criteria, found in 42 CFR 422.113(c)(3) is met:

(i) A Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

(ii) A Contractor physician resumes responsibility for the Enrollee's care;

(iii) A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or

(iv) The Enrollee is discharged.

4.4.4 Limitation on Charges to Enrollees

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

4.5 Covered Services -- Care Provided in Skilled Nursing Facilities, Intermediate Care Facilities, and LTAC Hospitals

4.5.1 In General: Stays Lasting 30 Days or Less

The Contractor shall provide care for Enrollees in skilled nursing facilities, Intermediate Care Facilities, and Long Term Acute Care (LTAC) hospitals and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 days. It is the responsibility of a Network Provider to make the determination whether the Enrollee shall require the service of a nursing facility, Intermediate Care Facility, or LTAC for more or less than 30 days.

4.5.2 Process for Stays More than 30 Days

(A) When the prognosis of an Enrollee indicates that care in a nursing, Intermediate Care Facility or LTAC facility for more than 30 days will be required, the Contractor shall:

(1) Notify the Enrollee, hospital discharge planner, and nursing, Intermediate Care, or LTAC facility that the Contractor shall not be responsible for the services provided for the Enrollee during the stay at the facility; and

(2) Notify the Department's Bureau of Managed Health Care ("BMHC") of this determination and the BMHC shall change the status of the Enrollee to Fee-For-Service.

4.5.3 Process for Stays Initially 30 Days or Less Converted to Over 30 Days

(A) When the prognosis of skilled nursing, Intermediate Care, or LTAC facility services is anticipated to be 30 days or less, but during the 30 day period the Contractor determines that the Enrollee shall require skilled nursing, Intermediate Care or LTAC facility services for more than 30 days the Contractor shall:

(1) Notify the nursing, Intermediate Care, or LTAC facility that a determination has been made that the Enrollee will require services for more than 30 days; and

(2) Notify the BMHC of the determination that the Enrollee will require services in a nursing or LTAC facility for more than 30 days; and

(3) The Contractor shall be responsible for payment for three working days after the Contractor has notified the nursing, Intermediate Care, or LTAC facility that skilled nursing care will be required for more than 30 days.

4.5.4 Failure to Disenroll

The Contractor shall make a good faith effort to follow the above skilled nursing guidelines but the Contractor shall not be held financially responsible for services that are required for more than 30 days when the Contractor and the Department fail to get the Enrollee disenrolled according to the guidelines.

4.6 Covered Services – Hospice

4.6.1 Hospice, Generally

(A) If an Enrollee is receiving hospice services at the time of enrollment in the Health Plan or if the Enrollee is already enrolled in the Health Plan and has less than six months to live, the Contractor shall provide the Enrollee hospice services or the continuation of hospice services if he or she is already receiving such services prior to enrollment in the Health Plan.

(B) If the Enrollee is admitted to a nursing facility, ICF/ID or a freestanding hospice facility, the Contractor must reimburse the hospice Provider for both the hospice care and the room and board until the Enrollee is disenrolled from the Health Plan by the Department. When the Contractor determines that an Enrollee will require care in the hospice facility for more than 30 days, the Contractor shall notify the Enrollee, hospice agency, and hospice facility that the Enrollee will no longer be eligible for coverage of hospice services from the Contractor. The Contractor shall also notify the BMHC of this determination. The BMHC shall change the status of the Enrollee to Fee-For-Service.

(C) The Contractor shall pay for room and board expenses of a hospice Enrollee receiving Medicare hospice care while the Enrollee is a resident of a Medicare-certified nursing facility, ICF/ID, or freestanding hospice facility until the Enrollee is disenrolled from the Health Plan by BMHC.

4.7 Covered Services—Inpatient Hospital Services for Scheduled Admissions

4.7.1 Financial Responsibility for Inpatient Hospital Services

When the Contractor admits or authorizes an Enrollee for a covered inpatient hospitalization and the hospital stay is for a covered diagnosis, the Contractor shall be financially responsible for all charges relating to the Enrollee's hospital stay including, but not limited to, charges for related physician services, diagnostic tests, psychiatric consultations billed using CPT Code 90792, and pharmacy.

4.8 Covered Services—Children in Custody of the Department of Human Services

4.8.1 General Provisions

(A) The Contractor shall work with the Division of Child and Family Services ("DCFS") or the Division of Juvenile Justice Services ("JJS") in the Department of Human Services ("DHS") to ensure systems are in place to meet the heath needs of children in custody of DHS. The Contractor shall ensure these children receive timely access to appointments through coordination with DCFS or JJS. The Contractor shall have Network Providers available who have experience and training in abuse and neglect issues.

(B) When Contractor's Enrollee is a child who is in the custody of DHS, the child's care

coordination will be directed by DHS and DOH staff. The Contractor shall be responsible for payment of services delivered to the child. The child in custody may continue to use the Provider with whom the child has an established professional relationship when the Provider is a Network Provider. The Contractor shall facilitate timely appointments with the provider of record to ensure continuity of care for the child.

(C) While it is the Contractor's responsibility to ensure Enrollees who are children in the custody of DHS have access to needed services, DHS personnel are primarily responsible to assist children in custody in arranging for and getting to medical appointments and evaluations with the Contractor's Network Providers. DHS staff are primarily responsible for contacting the Contractor to coordinate care for children in custody and informing the Contractor of the Special Health Care Needs of these Enrollees. The Fostering Healthy Children staff may assist in performing these functions by communicating with the Contractor.

4.8.2 Children in Custody, Suspected Physical and/or Sexual Abuse

When DHS personnel suspect physical and/or sexual abuse, the Contractor shall ensure that the child has access to a Provider who can provide an appropriate examination within 24 hours of notification that the child was removed from the home. If the Contractor cannot provide an appropriate examination, the Contractor shall ensure the child has access to a Provider who can provide an appropriate examination within the 24 hour period. The Contractor shall be responsible for payment in the event that the child must be treated by a Non-Network Provider.

4.8.3 Children in Custody, Initial Health Screening

The Contractor shall ensure that a child in custody has access to an initial health screening within five calendar days of notification that the child was removed from the home. The Contractor shall ensure this exam identifies any health problems that might determine the selection of a suitable placement, or require immediate attention.

4.8.4 CHEC Exams

The Contractor shall ensure that children in custody have access to a Provider who can perform a Child Health Evaluation and Care ("CHEC") screening within 30 calendar days of notification that the child was removed from the home. Whenever possible, the CHEC screening should be completed within the five day time-frame. Additionally, the Contractor shall ensure that children in custody have access to a Provider who can perform a CHEC screening according to the CHEC periodicity schedule until age six, then annually thereafter until the age of 21.

4.9 Covered Services—Organ Transplantations

4.9.1 Generally

(A) All organ transplantation services are Covered Services for all Enrollees in accordance with the criteria set forth in Utah Administrative Code R414-10A. Both Parties agree that all

transplant services will be provided by in-network and in-state Providers unless the service is not available, as determined by the Contractor in consultation with its Network Providers, and must be performed by a Non-Network Provider or Out-of-State Provider.

(B) In accordance with Section 1903(i) of the Social Security Act, the Contractor is prohibited from paying for organ transplantations unless the Contractor follows the criteria set forth in the State Plan, Utah Administrative Code R414-10A and ensures that similarly situated individuals are treated alike and that any restrictions on facilities or providers be consistent with the accessibility of high quality care to Enrollees.

4.9.2 Specific Organ Transplantations Covered

The following transplantations are covered for Enrollees as described in Utah Administrative Code R414-10A: kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi-visceral, and combination liver/small bowel.

4.9.3 Psycho-Social Evaluation Required

Enrollees who have applied for organ transplantations, except cornea or kidney, shall undergo a comprehensive psycho-social evaluation. The evaluation shall include a comprehensive history regarding substance abuse and compliance with medical treatment. In addition, the parent(s) or guardian(s) of Enrollees who are less than eighteen years of age shall undergo a psycho-social evaluation that includes a comprehensive history regarding substance abuse, and past and present compliance with medical treatment. The psycho-social services shall be the responsibility of the Contractor and the Contractor is responsible for payment as a medical benefit.

4.9.4 Out-of- State Transplantations

When the Contractor arranges the transplantation to be performed out-of-state, the Contractor is responsible for coverage and payment of food, lodging, transportation and airfare expenses for the Enrollee and, if necessary, for a parent, guardian, and/or attendant. The Contractor shall follow the Department's criteria for coverage of food, lodging, transportation, and airfare expenses as outlined in the Utah Medicaid Provider Manual for Medical Transportation.

4.10 Covered Services—Mental Health Services

4.10.1 Mental Health Services, Generally

(A) When an Enrollee presents with a possible mental health condition to his or her Primary Care Provider, it is the responsibility of the Primary Care Provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health conditions may be handled by the Primary Care Provider or referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee.

(B) The Primary Care Provider may seek consultation from the Prepaid Mental Health Plan when the Primary Care Provider chooses to manage the Enrollee's symptoms.

4.11 Excluded Services—Habilitative and Behavioral Management Services

4.11.1 Generally

Habilitative and behavioral management services are not Covered Services. If habilitative services are required, the Contractor shall have a process to refer the Enrollee to the Division of Services for People with Disabilities ("DSPD"), the school system, the Early Intervention Program, or similar support agency. The Enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD. Habilitative services are defined in Section 1915(C)(5)(a) of the Social Security Act as "services designed to assist individuals in requiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

4.12 Covered Services-- Out-Of-State Accessory Services

4.12.1 Out-of-State Accessory Services, Generally

The Contractor shall follow the Department's criteria for out-of-state accessory services including coverage of food, lodging, transportation, and airfare expenses as outlined in the Utah Medicaid Provider Manual for Medical Transportation.

4.13 Covered Services—Additional Services for Enrollees with Special Health Care Needs

4.13.1 Identification of Enrollees with Special Needs

(A) The Contractor shall have policies and procedures in place to identify Enrollees and Children With Special Health Care Needs using a process at the initial contact between the Contractor and Enrollees. The Contractor shall also have procedures in place to identify existing Enrollees and Children who may have Special Health Care Needs.

(B) The Contractor shall implement mechanisms to assess Enrollees with Special Health Care needs to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

(C) The Contractor shall notify the Department of any Enrollees it identifies who need LTSS services. The Contractor shall coordinate with the Department to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. The Contractor shall produce a treatment or service plan for Enrollees who require LTSS, to the extent that those services are Covered Services under this Contract.

4.13.2 Primary Care Provider for Enrollees With Special Needs

(A) The Contractor shall have policies and procedures to inform caregivers, and when appropriate, Enrollees With Special Health Care Needs, about Primary Care Providers who have training in caring for such Enrollees.

(B) The Contractor shall contract with Primary Care Providers with skills and experience to meet the needs of Enrollees with Special Health Care Needs.

(C) For Enrollees determined to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Enrollees to directly access a specialist (for example, through standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs. The Contractor shall allow an appropriate specialist to be the Enrollee's Primary Care Provider but only if the specialist has the skills to monitor the Enrollee's preventative and primary care services.

4.13.3 Referrals and Access to Specialty Providers

(A) The Contractor shall ensure that there is access to appropriate specialty providers to provide Medically Necessary Covered Services for Adults and Children With Special Health Care Needs. If the Contractor does not employ or contract with a specialty provider to treat a special health care condition at the time the Enrollee needs such Covered Services, the Contractor shall have a process to allow the Enrollee to receive Covered Services from a qualified specialist who may not be affiliated with the Contractor. In such instances the Contractor shall be responsible for payment, even if the Provider is a Non-Network Provider. The process for requesting specialist care shall be clearly described by the Contractor in the Contractor's Member Handbook, and explained to each Enrollee during the initial contact with the Enrollee.

(B) The Contractor shall not limit the number of referrals to specialists that a Provider may make for an Enrollee or Child with Special Health Care Needs.

4.13.4 Collaboration with Other Programs

(A) If an Enrollee With Special Health Care Needs is enrolled in a Prepaid Mental Health Plan or is enrolled in any of the Medicaid home and community-based waiver programs and is receiving case management services through that program, or is covered by one of the other Medicaid targeted case management programs, the Contractor's care coordinator shall collaborate with the appropriate program person for that program. The Contractor shall share with other MCEs contracted with the Department who are serving Enrollees with Special Health Care Needs the results of its identification and assessment of each Enrollee's needs to prevent duplication of activities.

(B) The Contractor shall coordinate health care needs for Enrollees with Special Health Care Needs with Enrollee's families, caregivers, and advocates.

(C) The Contractor shall coordinate health care needs for Enrollees with Special Health Care Needs with the services of other agencies such as mental and substance abuse, public health departments, transportation, home and community based care, developmental disabilities, Title V, local schools, IDA programs, and child welfare, and with families, caregivers, and advocates.

4.13.5 Case Management and Coordination of Care Program

(A) The Contractor shall have policies and procedures in place to assure continuity and coordination of overall health care for all Enrollees including a mechanism to ensure that each Enrollee has an ongoing source of Primary Care.

(B) The Contractor's case management program shall be designed around a collaborative process of assessment, planning, facilitation, and advocacy using available resources to promote quality, timely, safe and cost-effective outcomes. The Contractor shall use the information the Department provides on Enrollees with Special Health Care Needs to coordinate care and determine case management needs.

(C) A case management program can include, but is not limited to:

(1) Methodologies to determine the frequency and duration of case management services through application of the Health Plan's criteria;

(2) Mechanisms to refer to and coordinate with other state agencies and community resources as necessary;

(3) Assisting with and the monitoring of Enrollees' follow-up and specialty care to ensure compliance with optional treatment plans and ensure that Enrollees receive recommended follow up and specialty care;

(4) Coordination with the Contractor's disease management program;

(5) Referral of enrollees to Medical Homes, where appropriate; and

(6) Protocols to address Enrollees who are non-compliant.

4.14 Pharmacy Benefits

4.14.1 Pharmacy, Generally

(A) The Contractor shall cover prescription drugs as a Covered Service as stated under this Contract and in compliance with Federal and State Laws.

(B) All covered drugs or related products must have a valid NDC number.

(C) The Contractor shall ensure that its Network Providers are writing prescriptions on a tamper-resistant prescription pad in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recover, and Iraq Accountability Appropriations Act of 2007.

(D) The Contractor shall designate a pharmacy benefit manager responsible for processing pharmacy claims, sending the post-adjudication file, and who shall act as the Contractor's technical liaison with the Department for pharmacy-related issues.

(E) The Contractor shall have a co-pay accumulator capable of tracking pharmacy co-pays made by the Contractor's Enrollees.

(F) The Contractor shall reimburse an Enrollee any overpaid pharmacy co-pays, at minimum, on a quarterly basis. However, if an Enrollee requests reimbursement for an overpaid pharmacy co-pay the Contractor shall reimburse the Enrollee within 10 business days from the date of the Enrollee's request.

(G) The Contractor shall develop policies and procedures to govern prescription drug service authorizations. The prescription drug service authorization policies and procedures shall follow those same service authorization procedures found in Article 7 of this Contract, 42 CFR 438.210, and section 1927(d)(5) of the Social Security Act. For all covered outpatient drug service authorizations, the Contractor shall provide notice as described in section 1927(d)(5). Under this section, the Contractor may require as a condition of coverage or payment for a covered outpatient drug, for which Federal Financial Participation is available, the approval of the drug before its dispensing for any medically accepted indication only if the system providing for such approval provides response by telephone or other telecommunication device within 24 hours of a Service Authorization Request.

4.14.2 Covered Drugs, PDL-Plus File

(A) The Department shall electronically provide to the Contractor a data feed which shall be designated the PDL-Plus file. The Department shall make reasonable efforts to provide the PDL-Plus file on a weekly basis.

(B) The PDL-Plus file shall contain a list of drugs with indicators specifying:

(1) the drugs that the Contractor is responsible for covering;

(2) the drugs which are carved out of the Contractor's coverage responsibility but will still be covered by the Department;

(3) the prescription drugs and compounds which are eligible for a rebate under the Medicaid Drug Rebate Program enacted by the Omnibus Budget Reconciliation Act of 1990;

(4) the DME which the Contractor is responsible for covering as a pharmacy benefit;

(5) the over-the-counter drug categories that the Contractor is responsible for covering; and

(6) the non-rebateable drugs the Contractor is responsible for covering.

(C) The Contractor shall ensure that it is using the most accurate and up-to-date PDL-Plus list. In the event the Contractor does not receive the weekly PDL file, the Contractor shall contact the Department to obtain the most recent file.

(D) The Contractor shall cover all of the drugs on the Department's PDL-Plus file which have an indicator as being covered, and not carved-out.

(E) The Contractor shall provide coverage of outpatient drugs as defined in Section 1927(k)(2) of the Social Security Act, that meets the standards for such coverage imposed by Section 1927 of the Act as if such standards applied directly to the Contractor.

4.14.3 Non-Covered Drugs

(A) The Contractor shall submit, no later than 60 days after the end of each quarter, a report of drugs which the Contractor has elected to cover, but which are not indicated as being covered drugs on the PDL-Plus file. The report shall be in a format designated by the Department.

(B) In calculating the Capitation Rate, the Department shall not include as service costs the drugs which the Contractor has elected to cover, but which are not indicated as being covered drugs on the PDL-Plus file.

(C) In calculating the Capitation Rate, the Department shall not include as service costs drugs which have not been prescribed by an enrolled Utah Medicaid Provider.

4.14.4 Rebateable Drugs

(A) The Department shall retain all money collected from Primary Rebates available under the Medicaid Drug Rebate Program.

(B) The Contractor shall retain all money from rebates or discounts that the Contractor has negotiated with drug manufacturers.

(C) The Contractor shall submit a quarterly report, no later than 60 days after the end of the quarter, to the Department estimating the projected amounts of savings that the Contractor will incur as a result of any rebates or discounts negotiated with drug manufacturers. The Contractor shall provide an annual report, no later than 180 days from the end of each calendar year, of any actual rebates or discounts negotiated with drug manufacturers. The quarterly and annual reports shall be in a format designated by the Department.

(D) The Contractor shall report drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period. Such drug utilization information shall include, at a minimum, information on the total number of units of each dosage form, strength, and package size by NDC of each covered outpatient drug dispensed or covered by the Contractor.

(E) If drugs paid by the Contractor are subject of a rebate dispute from the drug manufacturer, the Contractor shall respond to any request for additional information regarding the dispute from the Department or the Department's representative within 30 days of the request date.

4.14.5 Physician Enrollment with Medicaid

(A) Each work-day, the Department shall electronically send to the Contractor an electronic file designated the Prescriber/Provider file.

(B) The Prescriber/Provider file shall include a list of all Providers who are enrolled with Utah Medicaid.

(C) The Contractor shall ensure that its Network Providers are enrolled with Medicaid.

(D) The Contractor is responsible for ensuring that its Network Providers are familiar with the Contractor's Preferred Drug List and are aware of which drugs are Covered Services.

4.14.6 Preferred Drug List

(A) The Contractor shall develop policies and procedures to govern prescription drug Service Authorization Requests , the policies and procedures shall follow those same Service Authorization Requests policies found in Article 7 and shall be in accordance with 42 CFR 438.210.

(B) The Contractor may use the Department's Preferred Drug List or may create its own Preferred Drug List.

(C) If the Contractor decides to create its own Preferred Drug List, the Contractor's Preferred Drug List shall adhere to the following requirements:

(1) On a yearly basis, the Contractor's Preferred Drug list and the methodology used by the Contractor to set is Preferred Drug List shall be subject to review by the Department's P&T Committee. Additionally, the P&T Committee at its discretion, may request and review Contractor's Preferred Drug List and require the Contractor to provide an explanation of the methodology used by the Contractor in making its Preferred Drug List.

(i) The Contractor shall provide any documents requested by the P&T Committee within 15 days of the request.

(ii) The Department's P&T Committee may require the Contractor to amend its Preferred Drug List if the Board determines that the Contractor's Preferred Drug List violates this Contract, violates applicable State and Federal Laws, or appears to create an adverse selection process.

(2) The Contractor shall make its Preferred Drug List, and the criteria used to create the Preferred Drug List available to the Department and to Contractor's Enrollees, upon request.

(3) If the Contractor fails to respond to P&T Committee request for information in a timely manner, the Department may impose sanctions as described in Article 14 of this Contract.

(4) The Contractor may file a request for an administrative hearing if it disagrees with the decision made by the Department's P&T Committee. The Contractor shall file its request for a State Fair hearing within 30 days of the P&T Committee's decision.

4.14.7 Enrollees Eligible for Medicare Part D

(A) Outpatient drugs covered under Medicare Prescription Drug Benefit Part D for full-benefit dual eligible Enrollees shall not be covered by the Contractor in accordance with Section 1935(a) of the Social Security Act.

(B) The Contractor shall not cover drugs excluded under Medicare Part D for dual eligible Enrollees except certain limited drugs which are provided, in accordance with Section 1927(d)(2) of the Social Security Act, to other Medicaid recipients including those who are full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit Part D.

4.14.8 Post-Adjudication History File

(A) The Contractor shall electronically submit a Post-Adjudication History File to the Department. The Post-Adjudication History File shall be in a format requested by the Department and shall be based on an NCPDP format. The Contractor shall submit its Post-Adjudication History file at the end of every batch cycle whether the batch is weekly, every two weeks, or every two months.

(B) Contractor must ensure that its Post-Adjudication History File is accurate.

(C) The Contractor shall correct any errors found in the Post-Adjudication History File within 90 days of the discovery of the error by the Contractor or Department. If the Contractor fails to correct the errors found in the Post-Adjudication History File, the Department may impose sanctions as described in Article 14 of the Contract.

4.14.9 Federal Drug Utilization Review Reporting

(A) The Contractor shall assist the Department in collecting any data that the Department needs to complete the Federal Drug Utilization Review Report.

(B) The Contractor shall provide the Department with any information requested by the Department to complete the Federal Drug Utilization Review report within 30 days of the Department's request. If the Contractor fails to respond to the request in a timely manner, the Department may impose sanctions as allowed in Article 14 of this Contract.

4.14.10 Special Rules for 340B Drug Pricing Program

(A) The Contractor's Network Providers may use drugs purchased under the 340B Drug Pricing Program enacted by Public Law 102-525, Codified in Section 340B of the Public Health Services Act.

(B) In the event that the Contractor's Network Providers elect to use drugs purchased under the 340B Drug Pricing Program, the Contractor shall identify on its Encounter Data all claims reported by Providers that utilized 340B stock by adding a value of "20" to the submission clarification code field on the pharmacy Encounter Data. By indicating on the NCPDP Post-Adjudication History File, the Contractor is certifying that the prescription satisfies all requirements for 340B drug as described in Public Law 102-525, Codified in Section 340B of the Public Health Services Act, and its implementing regulations.

(C) The Department, on a quarterly basis, shall invoice the Contractor for the Medicaid Drug Rebate equivalent associated with 340B dispensed drugs based on the 340B indicator entered by the Contractor on the NCPDP Post-Adjudication History File. The Contractor shall pay the Department within 30 days of the date of the invoice.

4.14.11 Additional Pharmacy Requirements of the Social Security Act

(A) Pursuant to Section 1903(m)(2)(A)(xiii) of the Social Security Act, an outpatient drug dispensed as a Covered Service to an Enrollee shall be subject to the same rebate requirements that the Department is subject to under Section 1927 of the Social Security Act and the Department shall collect such rebates from manufacturers and shall retain the rebate payments.

(B) Pursuant to Section 1903(m)(2)(A)(xiii) of the Social Security Act, the Contractor shall report to the Department on a timely and periodic basis specified by the Secretary of the U.S. Department of Health and Human Services, information on the total number of units of each dosage from and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage (other than outpatient drugs) and other data as deemed necessary by the Secretary of the U.S. Department of Health and Human Services.

4.14.12 Drug Utilization Review Program

(A) The Contractor shall operate a drug utilization review program that includes prospective drug review, retrospective drug use review, and an educational program as required at 42 CFR 456, subpart K.

(B) The Contractor shall provide a detailed description of its drug utilization review program activities to the State on an annual basis, as directed by the Department.

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 qualifiedNetwork 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, 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 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 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 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 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 requriements.

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 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

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 Section 1128(b)(8) of the Social Security Act;

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

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

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

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

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

Article 6: Program Integrity Requirements

6.1 Fraud, Waste and Abuse

6.1.1 Generally

(A) Pursuant to 42 CFR 438.608, the Contractor shall have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Waste, and Abuse on the part of the Providers, Enrollees, and other patients who falsely present themselves as being Medicaid eligible.

(B) The Contractor's compliance plan shall be designed to identify and refer suspected Fraud, Waste, and Abuse activities. The Contractor shall submit the compliance plan to the on July 1st and January 1st of each year for the Department's review.

(C) The Contractor's compliance plan shall include a description of the Contractor's Fraud, Waste, and Abuse case management tracking system. If the Contractor does not have a Fraud,

Waste, and Abuse case management tracking system the Contractor shall describe its plans to develop such a tracking system.

(D) The Contractor's compliance plans shall designate the staff members and other resources being allocated to the prevention, detection, investigation and referral of suspected Provider Fraud, Waste, and Abuse.

(E) The Contractor's compliance plans shall include a description of the Contractor's payment suspension process and how this process is in compliance with Article 6.1.5.

(F) The Contractor shall cooperate and coordinate with the Department, the Utah OIG, and the Medicaid Fraud Control Unit ("MFCU") in any Waste, Fraud, and Abuse activities and investigations.

(G) The Contractor shall make reasonable efforts to attend and participate in quarterly Fraud, Waste, and Abuse meetings with the Department, MFCU, and the Utah OIG.

6.1.2 Specific Requirements for Contractor's Management Arrangements or Procedures

(A) The Contractor's (and Subcontractor's to the extent that the Subcontractor is delegated responsibility for coverage of services and payments of claims) shall implement and maintain management arrangements or procedures and compliance plan to guard against Fraud, Waste, and Abuse shall include the following:

(1) Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all Federal and State standards;

(2) The designation of a compliance officer and a regulatory compliance committee that are accountable to senior management;

(3) Effective training and education for the compliance officer, Contractor's senior management, and the Contractor's employees for the Federal and State standards and requirements under this Contract;

(4) Effective lines of communication between the compliance officer and the Contractor's employees;

(5) Enforcement of standards through well-publicized disciplinary guidelines;

(6) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or

coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract,

(7) Provisions for internal monitoring and auditing including:

(i) Mechanism(s) for verifying with Enrollees that Covered Services provided or reimbursed by the Contractor were actually furnished to Enrollees (such as periodic questionnaires, telephone calls, etc., to a sample of Enrollees); and

(ii) Documentation of the sampling methodology and the schedule for conducting the verifications; and

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

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

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

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

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

(13) As detailed in Article 6.1.5, a Provision for the Contractor's suspension of payments to a Network Provider for which the Department determines there is a credible allegation of Fraud.

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

(A) Pursuant to Utah Code Ann. §63A-13-101 *et seq.*, if the Contractor or a Provider becomes aware of potential Provider-related Fraud, Waste, or Abuse, the Contractor or the Provider shall report the incident, in writing, to the Utah Office of Inspector General of Medicaid Services ("Utah OIG") and MFCU in the Utah Attorney General's Office.

(B) If the Contractor or Provider reports an incident to the Utah OIG or MFCU, the Contractor or Provider shall electronically submit a copy of the report to the Department.

(C) Reports of Fraud, Waste, or Abuse made by the Contractor or a Provider shall be made to the Utah OIG or MFCU and the Department within fifteen working days of detection of the incident of Provider-related Fraud, Waste, or Abuse.

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

(1) Name and identification number of the suspected individual;

(2) Source of the complaint (if anonymous, indicate as such);

(3) Type of Provider or type of staff position, if applicable;

(4) Nature of complaint;

(5) Approximate dollars involved, if applicable and

(6) The legal and administrative disposition of the case, if any, including actions taken by law enforcement to whom the case has been referred.

(E) In accordance with 42 CFR 455.17(a) the Contractor shall report to the Department on a quarterly basis the number of complaints of Fraud, Waste, and Abuse has warranted a preliminary investigation. The report shall be submitted to the Department no later than 30 days after each quarter.

(F) The Contractor shall provide a quarterly report of the Providers which the Contractor has taken any adverse action against for program integrity reasons.

6.1.4 Reporting Recipient-Related Fraud, Waste, and Abuse

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

6.1.5 Obligation to Suspend Payments to Providers

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

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

6.1.6 Service Verification

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

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

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

(B) By November 1st of each year, the Contractor shall submit a report to the Department, in a Department specified format:

(1) the names of all Enrollees contacted for service verification;

(2) whether the Enrollees were contacted via telephone, email, or other method;

(3) whether the Enrollee responded to the service verification; and

(4) whether the Enrollee indicated he or she obtained the service during the prior fiscal year.

(C) The Parties understand and agree that the Department will annually conduct an audit to ensure that the service verification was conducted by the Contractor. The Contractor shall keep sufficient documentation to ensure that the Department can verify that the service verification was performed.

6.1.7 Subrogation of Claims Arising from Fraud

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

6.2 False Claims Act

6.2.1 False Claims Act, Generally

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

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

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

(2) **Agent or contractor:** includes any contractor, subcontractor, agent or other person which or who, on behalf of the Contractor, furnishes or otherwise authorizes the furnishing of Medicaid Covered Services, performs billing or coding functions, or is involved in monitoring of health care provided by or on behalf of the Contractor.

6.2.2 Information Required in False Claims Act Policies

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

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

6.2.3 Dissemination of False Claims Act Policies and Procedures

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

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

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

6.2.4 Employee Handbook

(A) If the Contractor has an employee handbook, the Contractor shall include the following information:

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

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

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

6.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

6.3.1 General Requirements

(A) In accordance with Section 1932(d) of the Social Security Act and 42 CFR 438.610:

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

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

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

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

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

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

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

6.3.2 Screening for Prohibited Affiliations

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

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

(1) Directors, officers, or partners of the Contractor (including the Contractor's Board of Directors, if applicable);

(2) Subcontractor as governed by 42 CFR 438.230;

(3) Persons with beneficial ownership of 5 percent or more in the Contractor's equity;

(4) Network Providers; or

(5) Persons with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligation under this Contract with the Department.

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

(1) Conduct searches of the LEIE and EPLS databases and any other database required by the Department to ensure that the individuals listed in Article 6.3.2(B)(1),(2), (3), (4), and (5) have been debarred, Suspended, or otherwise Excluded; and

(2) The Contractor shall maintain documentation showing that such searches were conducted.

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

(1) The Contractor may provide the Department's Prohibited Affiliation Attestation Form to the individuals listed in Article 6.3.2(B)(1), (2) (3), (4) and (5). If the Contractor chooses to use the Department's Prohibited Affiliation Form, the Contractor shall keep the original version of this form and shall provide the Department with an electronic copy of the form.

(2) The Department's Prohibited Affiliation Attestation form includes a statement that if the individual completing the form subsequently becomes an affiliate of a person who is disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the individual must notify the Contractor within 30 days of the discovery and complete a new attestation form.

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

(F) For relationships with the individuals listed in Article 6.3.2(B)(1), (2), (3), (4) and (5) that exist on the effective date of this Contract, the Contractor shall perform the database searches and obtain the requisite attestations. Thereafter, the Contractor shall conduct monthly searches of the required databases to determine if those individuals have been added to the databases. The Contractor shall keep records showing that these monthly searches were conducted.

(G) If an entity other than the Contractor (for example, the Board of Directors) has the authority to enter into a relationship described in Article 6.3.2(B)(1), (2), (3), (4) and (5) of this Contract, then the Contractor or the other entity shall conduct the required database searches and obtain the requisite attestations. Thereafter the other entity or the Contractor shall conduct the monthly searches to ensure that those individuals have not been added to the databases. The party conducting the search shall keep records showing that these monthly searches were conducted.

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

6.3.3 Reporting Prohibited Affiliations

(A) In the event that the Contractor determines that it is not in compliance and has entered into a prohibited affiliation of the type described in Article 6.3 of this Contract, the Contractor must immediately, and no later than 30 days, notify the Department. Notification to the Department shall be by email and shall include the name, Social Security Number, and type of relationship the person has with the Contractor.

(B) If the Contractor obtains an Attestation from an individual stating that the individual has an Affiliate, as defined by the federal Acquisition Regulation, who has been disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the Contractor

shall provide an electronic copy of the attestation form to the Department no later than 30 calendar days from the date of the individual providing the attestation to the Contractor.

(C) The Department, after having been notified of the Contractor's noncompliance shall:

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

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

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

6.4 Excluded Providers

6.4.1 Definition of Excluded Providers

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

6.4.2 Screening for Excluded Providers

(A) The Contractor shall maintain written policies and procedures for conducting routine searches of the LEIE and EPLS databases and any other database required by the Department to ensure that the Providers are not restricted Providers.

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

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

(D) The Contractor shall conduct monthly searches of the LEIE and EPLS databases and any other database required by the Department to ensure that the Providers are not restricted Providers and maintain documentation showing that such searches were conducted.

(E) Once the Contractor has credentialed the potential Provider and enters into a Provider agreement, and the Provider is not Medicare-certified or is not a Medicaid Provider, the Contractor may delegate any of the following monthly searches:

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

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

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

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

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

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

6.4.3 Excluded Provider Payment Prohibition

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

6.5 Disclosure of Ownership and Control Information

6.5.1 Disclosure Information

(A) Using the Department's Managed Care Entity Disclosure Form, and in accordance with 42 CFR 455.104, the Contractor shall require the following disclosures:

(1) Each Person with an Ownership or Control Interest in the Contractor shall disclose:

(i) Identifying information that shall include the person's name, address, date of birth, Social Security Number (in the case of an individual) or other tax

identification number (in the case of a corporation). An individual shall disclose the address of his or her primary residence. A corporate entity shall include (as applicable) the primary business address, every business location and P.O. Boxes; and

(ii) Whether that person is related to another Person with an Ownership or Control Interest in the Contractor is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling.

(2) Each Person with an Ownership or Control Interest in a Subcontractor in which the Contractor has a five percent or more interest shall disclose:

(i) Identifying information that shall include the person's name, address, date of birth, Social Security Number (in the case of an individual) or other tax identification number (in the case of a corporation). An individual shall disclose the address of his or her primary residence. A corporate entity shall include (as applicable) the primary business address, every business location and P.O. Boxes; and

(ii) Whether that person is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling.

(3) Managing Employees shall disclose:

(i) Identifying information that shall include the name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

(4) Persons with an Ownership Interest in the Contractor shall disclose:

(i) Identifying information that shall include the name of the individual; and

(ii) the name of any Other Disclosing Entity (or Fiscal Agent or Managed Care Entity) in which the person with an Ownership Interest in the Contractor is also a Person with an Ownership or Control Interest in the Other Disclosing Entity (or Fiscal Agent or Managed Care Entity).

(5) In the event that the Contractor Subcontracts with an entity to perform administrative functions for the Contractor's Medicaid program, the Contractor shall require Persons with an Ownership or Control Interest in the Subcontractor to disclose the following information:

(i) Identifying information that shall include the person's name, address, date of birth, Social Security Number (in the case of an individual) or other tax identification number (in the case of a corporation). An individual shall disclose the address of his or her primary residence. A corporate entity shall include (as

applicable) the primary business address, every business location and P.O. Boxes; and

(ii) Whether that person is related to another Person with an Ownership or Control Interest in the Contractor is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling.

(6) In the event that the Contractor Subcontracts with an entity to perform administrative functions, for the Contractor's Medicaid program, the Contractor shall require Managing Employees of the Subcontractor to disclose the following information:

(i) Identifying information that shall include the name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

6.5.2 Reporting Timeframes

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

(1) Upon the Contractor submitting a proposal in accordance with State's procurement process.

(2) Upon the Contractor executing the Contract with the Department.

(3) Upon renewal or extension of the Contract.

(4) Within 35 calendar days after any change in Persons with Ownership or Control Interest.

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

(B) The Department shall review the ownership and control disclosure submitted by the Contractor and any of its Subcontractors.

6.5.3 Consequences for Failure to Provide Disclosures

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

6.6 Disclosure of Provider Incentive Plans

6.6.1 Generally

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

6.6.2 Prohibition

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

6.6.3 Reporting Requirements

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

(B) The Contractor shall report to the Department the following information in sufficient detail to determine whether the incentive plan complies with the regulatory requirements:

(1) Whether services not furnished by the physician or physician group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group;

(2) The type of incentive arrangement (e.g., withhold, bonus, capitation arrangement, etc.);

(3) The percent of withhold or bonus, if applicable;

(4) The panel size, and if Enrollees are pooled, the method used;

(5) If the physician or physician group is at substantial financial risk, proof the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss; and

(6) If required to conduct Enrollee surveys, the survey results.

6.6.4 Substantial Financial Risk

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

6.6.5 Information to Enrollees

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

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

7.1 Service Authorization and Notice of Adverse Benefit Determination

7.1.1 Policies and Procedures for Service Authorization Requests

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

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

(C) The Contractor shall ensure that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

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

(E) The Contractor shall ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue, Medically Necessary services to any Enrollee.

(F) The Contractor shall authorize any LTSS services, to the extent that the services are Covered Services under this Contract, based on the Enrollee's current needs assessment and consistent with the person-centered service plan.

7.1.2 Time Frames and Procedures for Standard Service Authorizations

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

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

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

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

(2) If the Contractor extends the time frame for making standard Service Authorization decisions the Contractor shall:

(i) Give the Enrollee written notice of the reason for the decision to extend the time frame;

(ii) Inform the Enrollee of his or her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

(iii) Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.3 Time Frames and Procedures for Denying All or Part of a Service Authorization

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

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

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

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

(2) If the Contractor extends the time frame for making standard Service Authorization decisions the Contractor shall:

(i) Give the Enrollee written notice of the reason for the decision to extend the time frame;

(ii) Inform the Enrollee of his or her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

(iii) Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.4 Time Frames and Procedures for Expedited Service Authorization Decisions

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

(1) Make an expedited Service Authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the receipt of the request for Service Authorization;

(i) The Contractor may extend the three working day time period by up to 14 calendar days if:

(a) the Enrollee requests the extension; or

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

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

7.1.5 Service Authorization Decisions Not Reached Within Required Time Frames

In the event that the Contractor fails to make a Service Authorization decision within the proscribed time frames, such failure shall constitute a denial of services and shall be considered an Adverse Benefit Determination. The Contractor is required send out a fit Determination to the Enrollee on the day that the time frame expires.

7.1.6 Decisions to Terminate, Suspend, or Reduce Previously Authorized Covered Services

(A) If the Contractor terminates, suspends or reduces previously authorized Covered Services this constitutes an Adverse Benefit Determination. The Contractor shall notify the requesting Provider and mail a Notice of Adverse Benefit Determination to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following time frames:

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

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

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

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

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

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

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

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

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

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

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

7.2 Other Adverse Benefit Determinations Requiring Notice of Adverse Benefit Determination

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

(A) The Contractor shall provide a written Notice of Adverse Benefit Determination to the the requesting Provider of decisions to deny payment in whole or in part.

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

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

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

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

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

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

(3) the Enrollee became eligible after the first of the month, but received a service during that month before becoming Medicaid eligible.

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

Any failure of the Contractor's Network Providers to provide services in a timely manner constitutes an Adverse Benefit Determination. The Contractor shall provide a Notice of Adverse Benefit Determination to the Enrollee at the time either the Enrollee or provider informs the Contractor that the provider failed to meet the performance benchmarks for appointment waiting times found in Article 10.2.6.

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

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

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

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

(D) If the Enrollee is not the Aggrieved Party, the Contractor shall provide the Notice of Action to the Enrollee as well as to the Aggrieved Party.

7.3 Required Content of Notice of Adverse Benefit Determination

7.3.1 Generally

(A) The Contractor's Notice of Adverse Benefit Determination shall be in writing and meet the language and format requirements outlined in in Article 3 to ensure ease of understanding.

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

(1) The Adverse Benefit Determination the Contractor has taken or intends to take;

(2) The reason for the Adverse Benefit Determination,;

(3) the right of the Enrollee to be provided and upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination (such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits);

(4) The date the Adverse Benefit Determination will become effective when the Adverse Benefit Determination is to terminate, suspend, or reduce a previously authorized Covered Service;

(5) The right to file an Appeal of the Adverse Benefit Determination with the Contractor;

(6) The procedures for filing an Appeal;

(7) The circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution;

(8) The Enrollee's right to have disputed services continue pending resolution of the Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider;

(9) How to request that the disputed services be continued, and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is adverse to the Enrollee, to the extent that they were furnished solely because of this Contract requirement in accordance with 42 CFR 438.420; 438.404(b)(6), and 431.230(b); and

(10) The following timeframe for filing an Appeal, as applicable:

(i) If the Enrollee is not requesting continuation of disputed services pending resolution of an Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by

an authorized Provider, and the original period covered by the original authorization has not expired, the Enrollee or the Provider, shall file the Appeal within 90 days from the date on the Contractor's Notice of Adverse Benefit Determination; or

(ii) If the Enrollee is requesting continuation of disputed services pending resolution of an Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider, and the original period covered by the original authorization has not expired, the Enrollee or Provider shall file the Appeal on or before the later of the following:

(a) within 10 days of the Contractor mailing the Notice of Adverse Benefit Determination; or

(b) by the intended effective date of the Contractor's proposed Adverse Benefit Determination.

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

(A) The Contractor shall develop and include as an attachment to the notice of Adverse Benefit Determination an Appeal Request form that an Aggrieved Person may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Aggrieved Person chooses to submit a written request for an expedited Appeals resolution, even though an oral request is all that is required. The form shall:

(1) Provide a prompt mechanism (through the use of check boxes or other means) for Aggrieved Persons to:

(i) request expedited Appeal resolution if they chose to submit a written request for an expedited Appeal resolution; and

(ii) request continuation of disputed services, if applicable;

(2) Provide a statement that if continuation of disputed services is requested when a previously authorized service is terminated, suspended or reduced, that the Enrollee agrees that the Contractor may recover from the Enrollee the cost of the services furnished while the Appeal is pending if the Appeal decision is adverse to the Enrollee, to the extent that the services were furnished solely because of the requirements of this Contract that are based on federal regulation in 42 CFR 438.420;

(3) Summarize the assistance available to the Aggrieved Person may request to complete the Appeal Request form and how to request the assistance; and

(4) Include a reminder that if the Aggrieved Person is not requesting an expedited Appeal resolution and the Enrollee files an Appeal orally, that the oral Appeal shall be followed by a written Appeal request within five working days from the date of the oral filing.

(B) When the Contractor is required to inform Aggrieved Persons of their State Fair hearing rights, the Contractor shall not attach its own Appeal Request form but shall, instead, attach the State's request form for a Medicaid State fair hearing.

Article 8 Grievance and Appeals Systems

8.1 Overall System

8.1.1 General Requirements

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

(1) a Grievance process whereby an Aggrieved Person, may communicate a Grievance;

(2) an Appeals process whereby an Aggrieved Person may file an Appeal of an Adverse Benefit Determination, and

(3) procedures for an Aggrieved Person to access the State's fair hearing system.

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

(C) To the extent that any written notice is required by Articles 8.1, 8.2, 8.3, 8.4 and 8.5, if the Enrollee is not the Aggrieved Party, the Contractor shall also provide a copy of notices to the Enrollee.

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

(A) The Contractor's process for Appeals shall:

(1) Provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as an Appeal, to establish the earliest possible filing date for the Appeal;

(2) Ensure that the Aggrieved Person understands that the oral Appeal shall be confirmed in writing, no later than five working days from the date of the oral filing, unless the Aggrieved Person requests an expedited resolution to the Appeal. These requests do not

require a follow-up written request;

(3) Provide the Aggrieved Person reasonable opportunity to present evidence and testimony and factual arguments, in person as well as in writing. The Contractor shall inform the Aggrieved Person of the limited time available for this in the case of an expedited Appeal resolution; and

(4) Provide the Aggrieved Person and his or her authorized representative the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records and any other documents and records considered during the appeals process, including any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal (this information must be provided free of charge and sufficiently in advance of the resolution timeframe)

(5) Include as parties to the Appeal:

(i) the Enrollee and his or her representative, or

(ii) the legal representative of a deceased Enrollee's Estate.

8.3 Standard Appeals Process

8.3.1 Authority to File

An Aggrieved Person may file an Appeal.

8.3.2 Timing

(A) The Aggrieved Person may file an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Contractor's Written Notice of Adverse Benefit Determination; or

(B) If the Adverse Benefit Determination being appealed is to terminate, suspend or reduce a previously authorized course of treatment, the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired, and the Enrollee wants disputed services to continue during the Appeal process, then the Enrollee or Provider shall file the Appeal on or before the later of the following:

(1) within 10 days of the Contractor mailing the Notice of Adverse Benefit Determination; or

(2) the intended effective date of the Contractor's proposed Adverse Benefit Determination.

8.3.3 Procedures

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

(B) Unless the Aggrieved Person requests an expedited resolution of the Appeal (which does not require a written follow-up request), the oral Appeal shall be followed with a written, signed Appeal. The written, signed Appeal must be received within five working days from the date of the oral Appeal. If the Aggrieved Person does not follow-up with a written, signed Appeal the Contractor has no further obligation to take action on the Aggrieved Person's Appeal.

(C) If an Aggrieved Person requests an expedited Appeal orally, the Contractor shall immediately inform Aggrieved Person that the oral filing of an Appeal must be followed with a written, signed appeal within five working days from the date of the oral Appeal unless the oral request for Appeal is a request for an expedited Appeal..

(E) The Contractor shall give Enrollees any reasonable assistance in completing required forms for submitting a written Appeal or taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.

(F) The Contractor shall acknowledge receipt of the Appeal either orally or in writing and explain to the Aggrieved Person the process that must be followed to resolve the Appeal.

(G) The Contractor shall provide the Aggrieved Person reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing. The Contractor shall inform the Aggrieved Party of the limited time available for this in the case of an expedited Appeal resolution.

(H) The Contractor shall provide the Aggrieved Party the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

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

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

(1) were not involved in any previous level of review or decision-making; and

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

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

(ii) an Appeal that involves clinical issues.

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

8.3.4 Time Frames for Appeal Resolution and Notification

(A) The Contractor shall resolve each Appeal and provide notice of resolution to affected parties as expeditiously as the Enrollee's health condition requires but no later than 30 calendar days from the day the Contractor receives the written, signed Appeal.

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

(1) the Aggrieved Person requests the extension; or

(2) the Contractor shows that (to the satisfaction of the Department, upon its request) there is no need for additional information and how the delay is in the Aggrieved Person's interest.

(C) If the Contractor extends the time frame, and the extension was not requested by the Aggrieved Party, the Contractor shall:

(1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;

(2) give the Aggrieved Person written notice, within two calendar days, of the reason for the Decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and

(3) resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.3.5 Format and Content of Notice of Appeal Resolution

(A) The Contractor shall provide written Notice of Appeal Resolution to the affected parties in a format and language that meets applicable notification standards found in 42 CFR 438.10. The written Notice of Appeal Resolution shall include the following:

(1) the results of the Appeal resolution process and the date it was completed; and

(2) for Appeals not resolved wholly in favor of the Aggrieved Party, the Contractor shall include the following in the written Notice of Appeal Resolution:

(i) the right to request a State fair hearing and how to do so;

(ii) the right to request continuation of disputed services if the Appeal decision is to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider and the original period covered by the original authorization has not expired;

(3) how to request continuation of disputed services;

(4) a statement that the Enrollee may be liable for the cost of disputed services provided if the State fair hearing decision upholds the Contractor's Adverse Benefit Determination;

(5) the time frame for requesting a State fair hearing when continuation of disputed services is not requested and when continuation of disputed services is requested; and

(6) as applicable, a copy of either:

(i) the standard request form for a Medicaid State fair hearing; or

(ii) the request form for an expedited State fair hearing that the Aggrieved Party must complete and submit to the Department to request a State fair hearing and continuation of disputed services; or

(iii) the standard request form for an expedited State fair hearing if the Aggrieved Party has an expedited Appeal.

8.3.6 Continuation of Disputed Services During the Appeals Process

(A) The Contractor shall continue the Enrollee's disputed services during the Appeal process if:

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

(2) the services were ordered by an authorized Provider;

(3) the original period covered by the original Service Authorization Request has not expired;

(4) the Aggrieved Party files the Appeal timely, which means filing the Appeal on or before the later of the following:

(i) within 10 days of the Contractor mailing the Notice of Adverse Benefit Determination; or

(ii) by the intended effective date of the Contractor's proposed Adverse Benefit Determination; and

(5) the Enrollee requests continuation of disputed services in the Appeal request.

8.3.7 Duration of Continued Disputed Services and Enrollee Responsibility

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

(1) the Enrollee withdraws the Appeal;

(2) ten days pass after the Contractor mails written Notice of Appeal Resolution that is adverse to the Enrollee and within that 10 day time period, and the Enrollee does not request a State fair hearing with continuation of disputed services until a State fair hearing decision is reached;

(3) a State fair hearing officer issues a hearing decision adverse to the Enrollee.

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

8.3.8 Reversed Appeal Resolutions

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

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

8.4 Process for Expedited Resolution of Appeals

8.4.1 General Requirements

(A) The Contractor shall establish and maintain an expedited review process when:

(1) The Contractor determines, based either upon a request from an Enrollee or in the

Contractor's own judgment, that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function; or

(2) A Provider indicates that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function.

8.4.2 Authority to File

The Aggrieved Person may file an expedited Appeal request either orally or in writing. Oral requests for expedited Appeal do not require a follow-up written request.

8.4.3 Timing

(A) The Aggrieved Person may file an Appeal of an Adverse Benefit Determination within 60 days from the date on the Contractor's Notice of Adverse Benefit Determination;

(B) If the Adverse Benefit Determination being appealed is to terminate, suspend or reduce a previously authorized course of treatment, the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired, and the Enrollee wants disputed services to continue during the Appeal process, then the Enrollee shall file the Appeal on or before the later of the following:

(1) within 10 days of the Notice of Adverse Benefit Determination; or

(2) by the intended effective date of the Contractor's proposed Adverse Benefit Determination.

8.4.4 Procedures for an Expedited Appeal

(A) When an Aggrieved Person requests an expedited resolution of an Appeal, the Contractor shall inform the Aggrieved Person of the limited time available for the Enrollee to present evidence and testimony and make legal and factual arguments in person and in writing.

(B) The Contractor shall ensure that punitive action is not taken against a Provider who either requests an expedited resolution to an Appeal or supports an Enrollee's Appeal.

(C) The Contractor shall give Enrollees any reasonable assistance in making an expedited appeal. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(D) The Contractor shall acknowledge receipt of the request for expedited Appeal resolution either orally or in writing and explain to the Enrollee the process that must be followed to resolve

the Appeal.

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

(1) were not involved in any previous level of review or decision-making nor a subordinate of any such individual; and

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

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

(ii) an Appeal that involved clinical issues.

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

(F) If the Aggrieved Party is not the Enrollee, the Contractor shall also provide the notices described in Article 8.4.4 to the Enrollee.

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

8.4.5 Denial of a Request for Expedited Appeal Resolution

(A) If the Contractor denies a request for an expedited resolution of an Appeal, the Contractor shall:

(1) Adjudicate the Appeal using the standard time frame of no longer than 30 calendar days from the day the Contractor receives the Appeal, with a possible 14 calendar day extension for resolving the Appeal and Providing Notice of Appeal resolution to affected parties;

(2) Make reasonable effort to give the Enrollee prompt oral notice of the denial; and

(3) Mail written notice within two calendar days explaining the denial, specifying the standard time frame that must be followed, and informing the affected parties that the

Enrollee may file a Grievance regarding the denial of expedited resolution of an Appeal.

8.4.6 Time Frame for Expedited Appeal Resolution and Notification

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

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

(1) the Aggrieved Person requests the extension; or

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

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

(1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;

(2) give the Aggrieved Person written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and

(3) resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.4.7 Format and Content of Expedited Appeal Resolution Notice

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

(B) The Contractor shall provide a written notice of Appeal Resolution that meets the same format and content requirements found in Article 8.3.5 of this Contract.

8.4.8 Continuation of Disputed Services During the Expedited Appeals Process

(A) The Contractor shall continue the Enrollee's disputed services during the expedited Appeal process if:

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

(2) the services were ordered by an authorized Provider;

(3) the original period covered by the original authorization has not expired;

(4) the Enrollee or Provider files the Appeal timely, which means filing the Appeal on or before the later of the following:

(i) within 10 days of the Contractor mailing the Notice of Adverse Benefit Determination; or

(ii) by the intended effective date of the Contractor's proposed Adverse Benefit Determination; and

(5) the Enrollee requests continuation of disputed services in the Appeal request.

8.4.9 Duration of Continued Disputed Services and Enrollee Responsibility

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

(1) the Enrollee withdraws the Appeal;

(2) ten days pass after the Contractor mails written Notice of Appeal Resolution that is adverse to the Enrollee and within that 10 day time period, and the Enrollee does not request a State fair hearing with continuation of disputed services until a State fair hearing decision is reached; or

(3) a State fair hearing officer issues a hearing decision adverse to the Enrollee.

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

8.4.10 Reversed Appeal Resolutions

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

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

8.5 State Fair Hearings

8.5.1 General Procedures

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

(B) The Contractor shall provide notification to Aggrieved Person that the final decision of the Contractor may be appealed to the Department and shall give to the Aggrieved Person the Department's form to request a State fair hearing. The Contractor shall inform the Aggrieved Person the time frame for requesting a State fair hearing as follows:

(1) The Department permits the Aggrieved Person, consistent with Utah Administrative Code R410-14-1, *et seq*., to request a state fair hearing within 120 days from the date of the Contractor's Notice of Appeal Resolution.

(2) If the Enrollee chooses to continue disputed services (when a previously authorized course of treatment has been terminated, suspended or reduced) pending the outcome of the State fair hearing and the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired, the request for a State fair hearing and continuation of disputed services shall be submitted within 10 days after the Contractor mails the Notice of Appeals Resolution.

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

(D) The parties to a State fair hearing shall be given an opportunity to examine at a reasonable time before the date of the hearing and during the hearing, the content of the Enrollee's case file and all documents and records to be used by the Contractor at the hearing.

(E) The parties to the State fair hearing shall be given the opportunity to:

(1) bring witnesses;

(2) establish all pertinent facts and circumstances;

(3) present an argument without undue interference; and

(4) question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

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

(G) The Aggrieved Party shall be notified in writing of the State fair hearing decision and any appeal rights as provided by State and Federal law.

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

(1) The State fair hearing shall take final administrative action within 90 days of the earlier of:

(i) the date the Enrollee filed an appeal with the Contractor, not including the number of days the Enrollee took to subsequently file for a State fair hearing; or

(ii) where permitted, the date the Enrollee filed for direct access to a State fair hearing;

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

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

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

8.6 Grievances

8.6.1 Authority to File a Grievance

(A) An Enrollee may file a Grievance; or

(B) A Provider may file a grievance.

8.6.2 Procedures

(A) The Enrollee or the Provider may file a Grievance orally or in writing, at any time, with the

Contractor.

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

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

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

(1) were not involved in any previous level of review of decision-making involving the Grievance nor a subordinate of any such individual;

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

(i) a Grievance regarding denial of a request for an expedited resolution of an Appeal; or

(ii) a Grievance that involves clinical issues; and

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

8.6.3 Timeframes for Grievance Disposition and Notification

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

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

(C) If the Enrollee or a Provider files a Grievance with the Department, the Department shall apprise the Enrollee or the Provider, of his or her right to file the Grievance with the Contractor and how to do so.

(1) If the Enrollee or Provider prefers, the Department shall promptly notify the Contractor of the Enrollee's Grievance.

(2) If the Contractor receives the Grievance from the Department, the Contractor shall follow the procedures and time frames outlined above for Grievances.

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

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

(1) the Enrollee requests the extension; or

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

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

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

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

8.7 Dispute Resolution, Reporting and Documentation

8.7.1 Reporting Requirements

(A) The Contractor shall maintain complete records of all Appeals and Grievances and submit semi-annual reports summarizing Appeals and Grievances using Department specified reporting templates. The Contractor shall separately track Grievances and Appeals that are relating to Children with Special Health Care Needs.

(B) The Contractor shall provide to the Department a summary of information on the number of Appeals and indicate the number of Appeals and Grievances that have been resolved. The Contractor shall include an analysis of the type and number of Appeals and Grievances.

8.7.2 Document Maintenance, Appeals

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

(1) a general description of the reason for the Appeal;

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

(3) written Notices of Adverse Benefit Determination;

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

(i) date of the oral requests;

(ii) date of acknowledgement of oral requests for expedited resolution of Appeals and method of acknowledgment (orally or in writing);

(iii) date of denials of requests for expedited Appeals resolution; and

(5) copies of written standard Appeal requests;

(6) copies of written notices of denial of requests for expedited Appeal resolution;

(7) date of acknowledgement of written standard Appeal requests and method of acknowledgment (orally or in writing);

(8) copies of written notices when extending the time frame for adjudicating standard or expedited Appeals when the Contractor initiates the extension;

(9) date of each review, or if applicable, review meeting;

(10) resolution and date of resolution at each level, if applicable;

(11) copies of written Notice of Appeal Resolution; and

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

8.7.3 Document Maintenance, Grievances

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

(1) general description of the reason for the Grievance;

(2) date the Grievance was received;

(3) date and method of acknowledgement (orally or in writing);

(4) name of the person taking the Grievance;

(5) name of the Enrollee for whom the Grievance was filed;

(6) date of each review, or if applicable, review meeting;

(7) date of resolution and summary of the resolution;

(8) name of person resolving the Grievance; and

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

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

Article 9 – Enrollee Rights and Protections

9.1 Written Information on Enrollee Rights and Protections

9.1.1 General Requirements

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

(B) The Contractors shall comply with any applicable Federal and State laws that pertain to Enrollee rights and ensure that its staff and Network Providers take those rights into accounts when furnishing services to Enrollees.

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

(D) The Contractor and the Department shall ensure Enrollees are free to exercise their rights, and that the exercise of those rights shall not adversely affect the way the Contractor and its Network Providers treat Enrollees.

9.1.2 Specific Enrollee Rights and Protections

(A) The Contractor shall include all of the following Enrollee rights and protections in its Enrollee handbook and in any other written Patient Rights statement:

(1) the right to receive information about Contractor's Health Plan;

(2) the right to be treated with respect and with due consideration for his or her dignity and privacy;

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

(4) the right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment;

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

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

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

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

9.2 Network Provider-Enrollee Communications

9.2.1 General Requirements

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

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

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

(3) the risks, benefits, and consequences of treatment or non-treatment; and

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

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 Generally

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

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

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

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

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

9.4 Advance Directives

9.4.1 Generally

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

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

(C) The Contractor shall educate staff concerning its policies and procedures on Advance Directives.

Article 10 – Contractor Assurances

10.1 General Assurances

10.1.1 Nondiscrimination

(A) The Contractor shall designate a nondiscrimination coordinator who shall:

(1) ensure the Contractor complies with Federal Laws and Regulations regarding

nondiscrimination; and

(2) take Grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, sex, sexual orientation, gender identity, disability, or age.

(B) The nondiscrimination coordinator may also handle Grievances regarding the violation of other civil rights as other Federal laws and regulations protect against these forms of discrimination.

(C) The Contractor shall develop and implement a written method of administration to assure that the Contractor's programs, activities, services and benefits are equally available to all persons without regard to race, color, national origin, sex, sexual orientation, gender identity, disability, or age.

10.1.2 Member Services Function

(A) The Contactor shall operate a Member Services function during Mountain Time regular business hours.

(B) As necessary, the Contractor shall provide ongoing training to ensure that the Member Services staff is conversant in the Contractor's policies and procedures as they relate to Enrollees.

(C) At minimum, Member Services staff shall be responsible for the following:

(1) explaining the Contractor's rules for obtaining services;

(2) assisting Enrollees to select or change Primary Care Providers; and

(3) fielding and responding to Enrollee questions including questions regarding Grievances.

(D) The Contractor shall conduct ongoing assessment of its orientation staff to determine staff members' understanding of the Health Plan and its Medicaid managed care policies and provide training, as needed

10.1.3 Provider Services Function

(A) The Contractor shall operate Provider Services function during Mountain Time regular business hours.

(B) At a minimum, Provider Services staff shall be responsible for the following:

(1) training, including ongoing training, of the Contractor's Providers on Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;

(2) assisting Providers to verify whether an individual is enrolled with the Health Plan;

(3) assisting Providers with prior authorizations and referral protocols;

(4) assisting Providers with claims payment procedures, including training Providers on how to bill using the National Provider Identification Number or the Department-assigned atypical provider identification number that is known to Medicaid to avoid rejection of Encounters; and

(5) Fielding and responding to Provider questions and the Grievance and Appeals System.

10.1.4 Enrollee Liability

(A) The Contractor shall not hold an Enrollee liable for the following:

(1) The debts of the Contractor if it should become insolvent.

(2) Covered Services provided to the Enrollee, for which:

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

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

(3) The payments to Providers that furnish Covered Services under a contract or other agreement with the Contractor that are in excess of the amount that normally would be paid by the Enrollee if service had been received directly from the Contractor.

10.2 Contractor Assurances Regarding Access

10.2.1 Documentation Requirements

(A) The Contractor shall provide the Department adequate assurances and supporting documentation that demonstrates the Contractor has the capacity to serve the expected enrollment in its Service Area with the Department's standards for access to care.

(B) The Contractor shall provide the Department documentation, in a format specified by the Department, that the Contractor offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of Enrollees for the Service Area, maintains a network of Network Providers that is sufficient in number, mix and geographic distribution to meet the anticipated number of Enrollees in the Service Area.

(C) The Contractor shall submit to the Department the documentation assuring adequate

capacity and services in the Department specified format no less frequently than:

(1) at the time it enters into a contract with the Department;

(2) at any time there has been a significant change (as defined by the Department) in the Contractor's operations that would affect adequate capacity and services including changes in services, benefits, geographic Service Area or payments, or enrollment of a new population in the Health Plan.

10.2.2 Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers and Physical Disability

(A) The Contractor shall minimize, with a goal to eliminate, the Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities.

(B) The Contractor shall provide assistance to Enrollees who have communications impediments or impairments to facilitate proper diagnosis and treatment.

(C) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TDD), and other auxiliary aids to all Enrollees as needed.

(D) The Contractor shall accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990, as amended.

(E) If the Contractor's facilities are not accessible to Enrollees with physical disabilities, the Contractor shall provide services in other accessible locations.

10.2.3 Interpretive Services

(A) The Contractor shall provide oral interpretive services available free of charge for all non-English languages, not just those the Department identifies as prevalent, on an as-needed basis. These requirements shall extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the Contractor and the Contractor's Network Providers and receive Covered Services.

(B) The Contractor shall ensure that interpretive services are provided in compliance with 45 CFR 92.201.

(C) The Contractor shall ensure that its Network Providers have interpretative services available.

(D) Nothing in this Article shall be construed to relieve Providers of their obligations to provide interpretive services under federal law.

(E) The Contractor shall cover interpretive services as described in the October 2013 Utah

Medicaid Provider Manual and Medicaid Information Bulletin.

10.2.4 Cultural Competence Requirements

(A) The Contractor shall ensure the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Enrollees have access to Covered Services that are delivered in a manner that meets their unique needs.

(B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and Network Providers which respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background and beliefs.

(D) The Contractor shall strive to ensure its Network Providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to Network Providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services.

10.2.5 No Restriction on Provider's Ability to Advise and Counsel

(A) The Contractor may not restrict a health care Provider's ability to advise and counsel Enrollees about Medically Necessary treatment options.

(B) All Providers acting within his or her scope of practice, shall be permitted to freely advise an Enrollee about his or her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

10.2.6 Waiting Time Benchmarks

(A) The Contractor shall adopt benchmarks for waiting times for physician appointments as follows:

(1) Benchmarks for Waiting Times for Appointments with a Primary Care Provider:

(i) within 30 days for a routine, non-urgent appointments

(ii) within 30 days for school physicals

(iii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

(2) Benchmarks for Waiting Times for Appointments with a Specialist:

(i) within 30 days for non-urgent care

(ii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

(B) These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

10.3 Coordination and Continuity of Care

10.3.1 In General

(A) The Contractor shall implement procedures to deliver care and to coordinate Covered Services for all Enrollees. These procedures must do the following:

(1) Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity;

(2) Coordinate the services the Contractor furnishes to the Enrollee:

(i) between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) with the services the Enrollee receives from any other MCO, PIHP or PAHP,

(iii) with the services the Enrollee receives in FFS Medicaid; and

(iv) with the services the Enrollee receives from community and social support workers.

(B) The Contractor shall make a best effort to conduct an initial screening of each Enrollee's needs within 90 days of the effective date of enrollment for all new Enrollees and shall make subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful.

(C) The Contractor shall share with the Department or other MCOs, PIHPs, and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(D) The Contractor shall ensure that each Provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards.

(E) The Contractor shall ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable.

(F) The Contractor's Network Providers are not responsible for rendering Home and Community-Based Waiver Services.

10.3.2 Primary Care

(A) The Contractor shall implement procedures to deliver Primary Care to and coordinate health care services for all Enrollees.

(B) The Contractor shall implement procedures to ensure that each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee. The Contractor shall provide the Enrollee information on how to contact his or her designated person or entity.

(C) The Contractor shall allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes Enrollees who are under the Restriction Program.

(D) If an Enrollee's Primary Care Provider ceases to participate in the Contractor's network, the Contractor shall offer the Enrollee the opportunity to select a new Primary Care Provider.

10.3.3 Prepaid Mental Health Plan

(A) When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the Contractor and Prepaid Mental Health Plan shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

(B) The Contractor shall educate its Network Providers regarding an effectiacve model of coordination between physical and mental health care services. The Contractor shall ensure its Network Providers coordinate the provision of physical health care services with mental health care services as appropriate.

(C) When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the Contractor shall not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered.

(D) Clients enrolled in the Health Plan and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this

Contract, but prescribed by the Prepaid Mental Health Plan physician, shall have access to such services in a timely fashion. The Contractor and Prepaid Mental Health Plan shall reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

10.4 Restriction Program

10.4.1 Restriction Program, Generally

(A) The Contractor shall develop policies and procedures consistent with the criteria found in Article 10.4.2 that the Contractor will use to screen for and manage Enrollees who are placed into the Restriction Program. The Contractor's policies and procedures must be approved by the Department. When providing its policies and procedures to the Department for approval, the Contractor shall also provide to the Department a copy of the correspondence it uses to implement its Restriction Program. The correspondence shall also be subject to the Department's approval.

(B) When an Enrollee is placed on the Restriction Program the Contractor may implement the restriction immediately, however, the restriction premium amount will not take effect until the month following the Enrollee being placed on the Restriction Program. The Contractor may limit the Enrollee's ability to obtain abused drugs unless the prescription is written by the restricted Enrollee's Primary Care Provider, mental health provider or other approved secondary prescriber and dispensed at an assigned pharmacy. The Contractor is responsible for paying for other Covered Services provided to the Enrollee until the eligibility file transmission indicates that the Enrollee has been placed on the Restriction Program.

(C) The Contractor shall be responsible for screening its Enrollees to determine whether or not the Enrollee should be placed into the Restriction Program. The Contractor shall provide to the Department, utilizing the Department's electronic form, information regarding an Enrollee who the Contractor has determined to be eligible for the Restriction Program. The Contractor shall provide this information to the Department within one business day of the Enrollee being deemed eligible for the Restriction Program.

(D) The Department shall periodically audit the Contractor's documentation indicating that it is placing an Enrollee on the Restriction Program. If the Contractor's documentation does not follow the criteria for placing the Enrollee on the Restriction Program the Department may, in its sole discretion, reject the Contractor's decision to place the Enrollee on the Restriction Program. In the event that the Contractor's determination to place an Enrollee on the Restriction Program is found to be invalid, the Department shall recoup the Restriction Premium from the date the Restriction is determined to be invalid and pay the Contractor at the appropriate Premium rate.

(E) When placing an Enrollee on the Restriction Program, the Contractor shall provide written notice to the Enrollee that the Enrollee is being placed on the Contractor's Restriction Program. The written notice shall include:

(1) The reason why the Enrollee is being placed on the Restriction Program;

(2) The Enrollee's right to file an Appeal (which shall follow the Standard Appeal Procedures found in Article 8.3 of this Contract); and

(3) The time frame in which the Enrollee must file an Appeal with the Contractor.

(F) Once the Enrollee has exhausted the Contractor's internal Appeals Process, the Contractor shall inform the Enrollee of his or her right to a State fair hearing and the timeframe in which the Enrollee must file a Request for a State fair hearing. The Contractor shall appear at the State fair hearing and defend the restriction. In the event that the Contractor fails to appear at the hearing, the Enrollee's Appeal will be automatically approved.

10.4.2 Restriction Program Criteria

(A) The Contractor shall use the following criteria to determine whether an Enrollee should be placed on the Restriction Program:

(1) An Enrollee has seen four or more PCPs in a maximum of 12 months, and/or four or more specialists.

(2) An Enrollee has utilized four or more pharmacies in a maximum of 12 months.

(3) The Enrollee has seen three or more Providers who prescribed Abuse Potential Medications in a two month period.

(4) The Enrollee has six or more prescriptions filled for Abuse Potential Medications in a two month period.

(5) The Enrollee has had five or more non-emergent Emergency Department visits in a 12 month period.

(6) The Contractor shall also take into consideration the following when determining whether to place a client on restriction:

(i) Enrollee Diagnosis;

(ii) Enrollee's concurrent prescribers; and

(iii) Limited access to care in rural areas.

(B) On an annual basis, the Contractor shall review the Enrollee's placement on the Restriction Program and shall make a determination as to whether the Enrollee should continue to be placed on the Program.

(C) The Department may amend the criteria for the Restriction Program. In the event the

Department changes the criteria, the Department shall provide 30 days written notice to the Contractor of the change in criteria. If the Contractor does not object to the criteria, within 15 days of receipt of the new criteria, the Contractor agrees to be bound by the new Restriction Program criteria.

(D) The Contractor shall place an Enrollee into the Restriction Program upon written request from the Department.

(E) The Contractor shall not place an Enrollee on the Restriction Program when the Enrollee is dually eligible and enrolled in Medicare.

10.4.3 Restriction Program Requirements

(A) The Contractor shall provide care coordination for its Enrollees on the Restriction Program, and shall provide to the Department on a quarterly basis, a staffing plan to ensure that the Contractor has an adequate number of Participating Providers to provide care to Enrollees on the Restriction Program.

(B) The Contractor shall provide staff that shall ensure that all Enrollees who are on the Restriction Program have a contact person to call when they have access problems, physician or pharmacy change requests, or other questions or problems.

(C) Once an Enrollee is placed on the Restriction Program, the Contractor shall provide the following services related to the Restriction Program:

(1) Provide the Enrollee an initial orientation about the Restriction Program and ongoing education on the appropriate use of medical services;

(2) Ensure access to medically necessary care, including urgent care and emergent care;

(3) Maintain a standardized care coordination & Restriction plan (in conjunction with the Enrollee's Primary Care Provider). The Contractor shall provide such plans to the Department upon request.

(D) The Contractor shall ensure that Enrollees who are on the Restriction Program are linked to a PCP who agrees to serve as a Restriction PCP. The Contractor shall notify a Provider serving as an Enrollee's assigned Restriction PCP of their responsibilities and, upon request of the Department shall provide documentation that the Contractor notified the Restriction PCP of their responsibilities. The Restriction PCP shall agree to the following:

(1) Manage all of the Enrollee's medical care;

(2) Educate the Enrollee regarding the appropriate use of medical services;

(3) Provide a referral to another physician when needed care is not within the PCP's field

of expertise, or when for some other reason the care cannot be provided by the PCP;

(4) Shall be telephonically available 24 hours a day, seven days a week (or make certain a Provider of comparable specialty is available) for urgent/emergent medical situations to assure the availability of prompt, quality, medical services and continuity of care;

(5) Manage acute and/or chronic long term pain through a variety of services or treatment options including, referral to a pain management specialist, office calls, medication administration, physical therapy, counseling and mental health referral with emphasis on teaching Enrollees to manage their pain by adapting actions and behaviors;

(6) Approve or deny drugs prescribed by other Providers when contacted by the pharmacy to which the Enrollee is restricted; and

(7) Work with pharmacy, specialists, dentists, behavioral health Providers, etc. sharing pertinent information regarding the Enrollee.

(E) If the Restricted Enrollee's PCP choses to no longer serve as the Enrollee's PCP, the Contractor shall assign a new Restriction PCP to the Enrollee within 30 days.

(F) If the Restricted Enrollee becomes eligible for FFS, the Contractor shall coordinate with the Department to ensure continuity of care for the Enrollee.

(G) In the event that the Contractor fails to follow restriction policies and procedures found in this Section 10.4 the Department shall pay the Contractor the non-restricted rate cell for the Enrollee.

(H) If a Restricted Enrollee in Fee for Service or another Managed Care Organization transfers to the Contractor, the Department shall coordinate with the Contractor to ensure all necessary information is obtained to continue the restriction and properly manage the Enrollee's care (including but not limited to assigned physicians and pharmacies).

(I) If there is a change in a Restricted Enrollee's PCP, Pharmacy, or Specialty Provider, the Contractor shall notify the Department within one working day of the change.

(J) Pursuant to 42 CFR 431.54(e)(3) and Article 4.3.1(E), an individual on the Restriction Program may receive emergency services from any Participating Provider or Non-Participating Provider.

10.5 Billing Enrollees

10.5.1 Enrollee Billing, Generally

(A) Except as otherwise provided for in this Contract, no claim for payment shall be made at any time by the Contractor or its Network Providers to an Enrollee accepted by that Network

Provider as an Enrollee for any Covered Service.

(B) When a Provider accepts an Enrollee as a patient he or she shall look solely to the Contractor and any third party coverage for reimbursement. If the Provider fails to receive payment from the Contractor, the Enrollee cannot be held responsible for these payments.

10.5.2 Circumstances in Which an Enrollee May Be Billed

(A) A Provider may bill an Enrollee for non-Covered Services only as outlined in this Contract.

(B) A non-Covered Service is a service that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee (e.g., more expensive eyeglass frames, hearing aids, custom wheelchairs, etc.) but does not meet the Medical Necessity criteria for amount duration, and scope as set forth in the State Plan or is not authorized by the Contractor.

(C) The Department shall specify to the Contractor the extent of Covered Service and items under the Contract as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis.

(D) An Enrollee may be billed for a non-Covered Service when all of the following conditions are met:

(1) The Provider has an established policy for billing all patients for services not covered by a third party (i.e., the charge cannot be billed only to Enrollees);

(2) The Provider has informed the Enrollee of its policy for billing patients for non-covered services;

(3) The Provider has advised the Enrollee prior to rendering the non-covered service that the Enrollee shall be responsible for making payment; and

(4) An agreement, in writing, is made between the Provider and the Enrollee that details the service and the amount to be paid by the Enrollee.

(E) The Provider may bill the Enrollee for disputed services continued during the Appeal process if the if the requirements of Article 8.4.9(B) of this Contract and 42 CFR 431.230(b) are met.

10.5.3 Prohibition on Holding Enrollee's Medicaid Card

The Contractor or its Network Providers shall not hold the Enrollee's Medicaid card as guarantee of payment by the Enrollee, nor may any other restrictions be placed on the Enrollee.

10.5.4 Medical Cards, Generally

If the Contractor elects to print its own cards for Enrollees, the Contractor and its Network Providers may not require the Enrollee to present their Contractor-printed card at the time of service. The only card that the Contractor may require is the Medicaid card issued by the Department.

10.5.5 Criminal Penalties

Criminal penalties shall be imposed on Providers as authorized under Section 1128B(d)(1) of the Social Security Act if the Provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

10.6 CHEC Requirements

10.6.1 General CHEC Requirements

(A) The Contractor shall provide services available to CHEC Enrollees pursuant to 42 USC 1396d(r).

(B) The Contractor shall provide to CHEC Enrollees Medically Necessary Covered Services and all other services required under 42 USC 1396d(r).

(C) The Contractor shall have a process in place through which CHEC Enrollees may request the services as described in Article 10.6.1(A) and (B).

Article 11 Payments

11.1 General Payment Provisions

11.1.1 Comprehensive Risk Contract

This Contract is a Comprehensive Risk Contract.

11.1.2 Payment Methodology

The payment methodology is described in Attachment F of this Contract.

11.1.3 Contract Maximum

In no event shall the aggregate amount of payments to the Contractor exceed the Contract maximum amount. If payments to the Contractor approach or exceed the Contract amount before the renewal date of the Contract, the Department shall make a good faith effort to execute a Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

11.1.4 Payment Recoupment

(A) The Department shall recoup any payment paid to the Contractor which was paid in error. Such error may include human or mechanical error on either part of the Contractor or the Department. Errors can include, but are not limited to, lack of eligibility or computer error.

(B) If the Contractor disagrees with the Department's determination that a payment was made in error, the Contractor may request an administrative hearing within 30 days of the Department's recoupment of the overpayment.

11.1.5 Overpayments

(A) The Contractor shall specify:

> (1) the retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse.
>
> (2) The Contractor shall specify the process, timeframes, and documentation required for reporting the recovery of all Overpayments.
>
> (3) The Contractor shall specify the process, timeframes, and documentation required for payment of recoveries of Overpayments to the Department in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

(B) The Contractor shall have and use a mechanism for a Network Provider to report to the Contractor when it has received an Overpayment, to return the Overpayment to the Contractor within 60 calendar days after the date on which the Overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

(C) The Contractor shall submit to the Department an annual report of Overpayment recoveries. The report shall be in a Department specified format.

11.2 Medicare

11.2.1 Payment of Medicare Part B Premiums

(A) The Department shall pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee shall assign to the Contractor his or her Medicare reimbursement for benefits received under Medicare.

(B) The Department shall identify on the Eligibility Transmission the Enrollees who are covered under Medicare.

11.2.2 Payment of Services Covered by Medicare

(A) The Contractor's payment for Medicare crossover claims shall be the allowed amount of Contractor's payment rate less any amounts paid by Medicare and other payors.

(B) When a service is paid for by Medicare, the Contractor shall pay in accordance with 12.2.2(A) of this Contract whether or not the service is covered under this Contract.

(C) The Contractor is responsible for payment whether or not the Medicare covered service is rendered by a Network Provider or has been authorized by the Contractor.

11.2.3 Prohibition on Balance Billing

The Contractor shall ensure its Network Providers will not balance bill the Enrollee. The reimbursement from Medicare and from the Contractor shall be payment in full.

12.2.4 Coordination of Benefits for Dual Eligibles

To the extent that 42 CFR 438.3(t) applies, the Contractor shall enter into a Coordination of Benefits Agreement with Medicare.

11.3 Third Party Liability and Coordination of Benefits

11.3.1 Recovery of Third Party Liability, Generally

The Contractor shall make reasonable efforts to pursue the recovery of Third Party Liability for Services provided to Enrollees. Third Party Liability may include, but is not limited to private health insurance, automobile insurance, Medicare, Tricare or an employer-administered ERISA plan.

11.3.2 Policies and Procedures for Third Party Liability Recovery

(A) The Contractor shall develop policies and procedures describing how it intends to conduct Third Party Liability recovery. Such policies and procedures shall be consistent with the requirements of 42 U.S.C. 1396(A)(25) and 42 CFR 433 Subpart D. The policies and procedures shall contain:

(1) Procedures and Mechanisms to identify potentially liable Third Parties;

(2) Procedures and Mechanisms to identify the amount owed by a Third Party; and

(3) Procedures and Mechanisms for recovery of Third Party Liability payments.

(B) In order to assist the Contractor, the Department shall include on the Eligibility Transmission other known health insurance plans available to each Enrollee. The Contractor shall report to the Office of Recovery Services any TPL discrepancies identified within 30

working days of receipt of the Eligibility Transmission. The Contractor's report shall include a listing of Enrollees that the Contractor has independently identified as being covered by another health insurance plan. The Contractor shall report changes to the Office of Recovery Services either by email (TPLChanges@utah.gov) or by fax (801-536-8912).

11.3.3 Pay and Chase and Cost Avoidance

(A) Contractor will use reasonable commercial efforts to evaluate the probable existence of Third Party Liability and may not shift that burden to a Provider. Probable existence of Third Party Liability exists where:

(1) the Contractor has confirmed that there was Third Party Liability in effect on the Enrollee's date of service; and

(2) the Contractor has determined that the Third Party Liability will likely cover the service received by the Enrollee.

(B) Except as otherwise provided in Article 11.3.3(C) of this Contract, when the Contractor is aware of the probable existence of Third Party Liability at the time a claim from a Provider is filed with the Contractor:

(1) The Contractor must reject the claim and return it to the Provider for a determination of the amount of liability.

(2) The establishment of Third Party Liability takes place when the Contractor receives confirmation from the Provider or a third party resource indicating the extent of third party liability. If the Provider or the third party gives reasonable evidence that the Third Party Liability was not in effect at the time of service or the service received by the Enrollee is not covered by the Third Party Liability the Contractor shall pay the claim, to the extent that the service is a Covered Service.

(3) When the amount of liability is determined, the Contractor must then pay the claim to the extent that payment allowed under the Contractor's payment schedule exceeds the amount of the third party's payment.

(C) In the following situations, the Contractor must pay the Provider's claim first and then seek reimbursement from the liable third party:

(1) the claim is prenatal care for women, or preventative pediatric services (including early and periodic screening, diagnosis and treatment services provided for under 42 CFR 441, Part B), and is covered under the State Plan;

(2) the claim is for a service covered under the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. In this instance the Contractor must pay the Provider if, after 30 days, it

has not received payment from the third party carrier.

(D) If the probable existence of Third Party Liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the Contractor must pay the claim pursuant to the Contractor's payment schedule. When the Contractor determines that Third Party Liability exists, the Contractor must seek reimbursement from the third party within 60 days of discovery of the Third Party Liability.

(E) Recovery is not required when claim is $100 or less for health insurance or $300 or less for cumulative claims.

(F) Contractor shall retain any payment it receives stemming from Third Party Liability. The Contractor shall report any Third Party Liability Recoveries on the 837 File.

11.3.4 Third Party Liability and Access to Care

(A) The Contractor cannot require an Enrollee to obtain Covered Services from Providers that accept the Enrollee's Third Party Liability.

(B) The Contractor shall pay Claims for Covered Services obtained by an Enrollee from a Network Provider even if the Network Provider does not accept the Enrollee's Third Party Liability.

(C) The Contractor shall pay Claims for Covered Services from a Non-Network Provider in the event that the Contractor has required the Enrollee to obtain Covered Services from the Non-Network Provider for the purposes of utilizing the Enrollee's Third Party Liability.

11.4 Personal Injury Cases

11.4.1 Notification of Personal Injury Cases

(A) The Contractor shall be responsible to notify the Office of Recovery Services (ORS) of all potential personal injury cases.

(B) Once a month, the Contractor shall submit to ORS a file of claims which includes personal injury diagnosis codes. The file shall be in a format required by ORS.

11.4.2 Request for Assignment

(A) The Contractor may request from the Department an assignment of the Department's right of recovery for an Enrollee who has a claim against a third party for an injury, disease or disability if:

(1) the Enrollee has not filed a claim or commenced an action for recovery or the Enrollee has not commenced an action pro se;

(2) the Enrollee does not have Fee-For-Service Claims, PMHP Claims, or Claims from another Health Plan which would be included in the action for recovery; and

(3) ORS has not already commenced an action for recovery.

(B) The Department may grant an assignment to the Contractor in accordance with 12.4.2(A) in its sole discretion. Any grant of an assignment shall be in writing. If the Department grants the assignment:

(1) the Contractor shall be required to update the Department with the status of the Contractor's recovery efforts upon request of the Department;

(2) the Contractor shall bear its own costs associated with the recovery;

(3) the Contractor shall report any Third Party Liability Recoveries on the 837 File;

(4) the Contractor shall be responsible for conducting any defense associated with any challenge of the assignment as well as costs associated with such defense; and

(5) any amounts recovered by the Contractor shall be retained by the Contractor.

(C) In any action commenced by ORS to pursue recovery of medical costs pursuant to Utah Code Ann. §26-19-7, the amounts recovered by ORS shall be retained by the Department.

11.5 Contractor's Payment Responsibilities

11.5.1 Covered Services Received Outside Contractor's Network but Paid by the Contractor

(A) The Contractor shall not be required to pay for Covered Services when the Enrollee receives the services from sources outside the Contractor's network, not arranged for and not authorized by the Contractor except as follows:

(1) Emergency Services;

(2) Court ordered services that are Covered Services defined in Attachment C and Attachment D; or

(3) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the Contractor's Network Providers.

11.5.2 Payment to Non-Network Providers

(A) Payment by the Contractor to a Non-Network Provider for Emergency Services for services that are approved for payment by the Contractor shall not exceed the lower of the following rates

applicable at the time the services were rendered to an Enrollee, unless there is a negotiated arrangement:

(1) The usual charges made to the general public by the Provider;

(2) The rate equal to the applicable Medicaid fee-for-service rate; or

(3) The rate agreed to by the Contractor and the Provider.

11.5.3 Covered Services which are Not the Contractor's Responsibility

(A) The Contractor may not restrict an Enrollee's choice of Provider for family planning services and supplies. The Contractor is not responsible for payment when family planning services are obtained by an Enrollee from a Non-Network Provider.

(B) The Contractor shall not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to earthquakes or acts of war. The effective date of excluding such Covered Services shall be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

(C) An Enrollee who is Indian may choose to seek Covered Services from an Indian Health Care Provider. The Contractor shall not be required to pay for Covered Services provided to Indian Enrollees who receive services provided by Indian Health Care Providers. Such services shall be paid by the Department.

11.5.4 Department Responsibility for Payment

Except as described in Attachment F or otherwise by this Contract, the Department shall not be required to pay for any Covered Services under Attachment C and Attachment D which the Enrollee receives from any source outside of the Contractor except for family planning services.

11.5.5 Covered Services Provided by the Utah Department of Health, Division of Family Health and Preparedness

(A) For Enrollees who qualify for special services offered by or through the Department of Health, Division of Family and Health Preparedness ("DFHP"), the Contractor agrees to reimburse DFHP at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee becomes a Medicaid Eligible Individual and selects the Contractor as its Health Plan.

(1) The Contractor agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit.

(2) The services provided in the outpatient team evaluation and follow-up visit for which

the Contractor shall reimburse DFHP are limited to the services that the Contractor is otherwise obligated to provide under this Contract.

(B) If the Contractor desires a more detailed agreement for additional services to be provided by or through DFHP for Children with Special Health Care Needs, the Contractor may subcontract with DFHP. The Contractor agrees that the subcontract with DFHP shall acknowledge and address the specific needs of DFHP as a government provider.

11.5.6 Administrative Fee for Immunizations

When an Enrollee under the age of 19 has third party coverage for immunizations, the Contractor shall pay the Provider the administrative fee for providing the immunization and not require the Provider to bill the third party. The Contractor may choose to pursue the third party for the administrative fee after the payment has been made to the Provider.

11.5.7 Payment for Services to Newborns

If a baby is born to an Enrollee, the Contractor is responsible for all inpatient facility and inpatient professional services for both the mother and the newborn Enrollee associated with the birth.

11.6 Enrollee Transition Between Health Plans or Fee-For-Service

11.6.1 Plan Transitions, Inpatient Hospital Stays

(A) When an Enrollee is in an inpatient hospital setting and selects another Health Plan or becomes Fee-For-Service any time prior to discharge from the hospital, the Contractor is financially responsible for the entire hospital stay including all services related to the hospital stay until discharged.

(B) If a Medicaid Eligible Individual is Fee-For-Service when admitted to the hospital and is enrolled in the Contractor's Health Plan at any time prior to discharge from the hospital, the Department is financially responsible for the entire hospital stay including all services related to the Hospital stay until discharged.

(C) The Health Plan in which the individual is enrolled when discharged from the Hospital is financially responsible for services provided to the Enrollee during the remainder of the month.

(D) If a Medicaid Eligible Individual is Fee-For-Service when discharged from the hospital, the Department is financially responsible for services provided to the Enrollee during the remainder of the month when the individual was discharged.

11.6.2 Enrollee Transition, Home Health Services

(A) Medicaid Eligible Individuals who are under Fee-For-Service or are enrolled in a Health Plan other than the Contractor's Health Plan and are receiving home health services from an agency not contracting with the Contractor, but who will transition to the Contractor's Health Plan, shall be transitioned to the Contractor's home health agency.

(B) The Contractor shall pay the Medicaid rate for services provided by an out-of-network Home Health Agency to an Enrollee until the Home Health Agency enrolls as a Network Provider with the Contractor or the Contractor provides an assessment to the Enrollee and transitions an Enrollee to an in-network Home Health Agency.

(C) The Contractor shall include the Enrollee in developing the plan of care to be provided by the Contractor's home health agency before the transition is complete. The Contractor shall make reasonable efforts to address the Enrollee's concerns regarding Covered Services provided by the Contractor's home health agency before the new plan of care is implemented.

11.6.3 Enrollee Transition, Medical Equipment

(A) When medical equipment is ordered for an Enrollee by the Contractor and the Enrollee enrolls in a different Health Plan or becomes Fee-For-Service before receiving the equipment, the Contractor is responsible for the payment of such equipment.

(B) When medical equipment is ordered for a Medicaid Eligible Individual by the Department and the Medicaid Eligible Individual selects a Health Plan, the Department is responsible for payment of such equipment.

(C) Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment are the responsibility of either the Health Plan (or the Department if the client was Medicaid fee-for-service) in which the client is enrolled at the time the equipment is ordered.

11.6.4 Contractor Acceptance of Pre-Enrollment Prior Authorization

Authorizations for medical care will be honored by the Contractor when authorized at a Network Provider. Service Authorizations at Non-Network Providers will be honored by the Contractor until it has evaluated the Medical Necessity of the requested service and agrees with the Department's Fee-For-Service Service authorization, has made a different determination or has made arrangements to have the service provided by a Network Provider.

11.6.5 Department Acceptance of Contractor's Prior Authorization

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an Enrollee transitions to Medicaid Fee-For-Service prior to the delivery of such Covered Service, the Department shall be bound by the Contractor's prior authorization until the Department has evaluate the medical necessity of the

service and agrees with the Contractor's Fee-For-Service prior authorization or has made a different determination.

11.6.6 Provision of Medical Information to Enrollee's Health Plan or the Department

When Medicaid Eligible Individuals are transitioned from the Contractor's Health Plan to Fee-For-Service or from Fee-For-Service to the Contractor's Health Plan, the Contractor and the Department, as applicable, shall submit upon request any critical medical information about the transitioning Medicaid Eligible Individual prior to the transition, including, but not limited to, whether the member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, names of the treating physicians, types of equipment ordered and dates, if on the Restriction Program, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill. Chronic illness includes, but is not limited to, diabetes, hemophilia, or HIV.

11.6.7 Acceptance of Pre-Enrollment Prior Authorizations

For Covered Services other than inpatient services, if authorization has been given for a Covered Service and a Medicaid Eligible Individual transitions between Health Plans prior to the delivery of such Covered Service, the receiving Health Plan shall be bound by the relinquishing Health Plan's prior authorization until the receiving Health plan has evaluated the medical necessity of the service and agrees with the relinquishing Health Plan's prior authorization or has made a different determination.

11.6.8 Provision of Medical Information to Enrollee's New Health Plan

When Medicaid Eligible Individuals are transitioned between Health Plans the relinquishing Health Plan shall submit, upon request of the new Health Plan, any critical medical information about the transitioning Medicaid Eligible Individual prior to the transition including, but not limited to, whether the Medicaid Eligible Individual is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, receiving dialysis or is chronically ill. Chronic Illness includes, but is not limited to, diabetes, hemophilia, or HIV.

11.6.9 Organ Transplant Prior Authorization

The Contractor shall honor prior authorizations for organ transplantations and any other ongoing services initiated by the Department while the Enrollee was covered under Medicaid Fee-For Service until the Enrollee is evaluated by the Contractor and a new plan of care is established.

11.6.10 Pharmacy Prior Authorizations

(A) The Contractor agrees that during the first 90 days of an enrollment that the Department's

Fee-For-Service prior authorization for pharmacy services or a prior authorization which has been issued to a CHIP Enrollee for pharmacy services will be honored for at least one temporary 30 day fill unless the prescription is written for less than 30 days by the prescriber.

Article 12 Additional Recordkeeping and Reporting Requirements

12.1 Recordkeeping Requirements

12.1.1 Health Information Systems, General Requirements

(A) The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including but not limited to, utilization, Claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

(B) The Contractor shall comply with Section 6504(a) of the Affordable Care Act which requires the Department claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meeting Section 1903(r)(1)(F) of the Social Security Act.

(C) The Contractor shall collect data on Enrollee and Provider characteristics as specified by the Department, and on all services furnished to Enrollees through an Encounter Data system or other methods as may be specified by the Department.

12.1.2 Accuracy of Data

(A) The Contractor shall ensure that the data received from Providers is accurate and complete by:

(1) verifying the accuracy and timeliness of the reported data, including data from Network Providers the Contractor is compensating on the basis of subcapitation payments;

(2) screening the data for completeness, logic, and consistency; and

(3) collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts.

(B) The Contractor shall make all collected data available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law.

12.1.3 Medical Records

The Contractor shall require its Network Providers to maintain a medical record keeping system that complies with state and federal law.

12.1.4 Document Retention Requirements for Awards

(A) The Contractor shall comply with the record retention and record access requirements for award recipients found in 45 CFR 74.53 which requires the Contractor to maintain financial records, supporting documents, statistical records, and all other records pertaining to an award to be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annual, from the date of the submission of the quarterly or annual financial report. The three year retention requirement does not apply:

(1) If any litigation, claim, financial management review or audit is started before the expiration of the 3 year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action apply;

(2) To records for real property and equipment acquired with Federal funds which shall be retained for 3 years after final disposition;

(3) When records are transferred to or maintained by the HHS awarding agency, the 3 year retention is not applicable to the recipient; and

(4) To indirect cost rate computations or proposals, cost allocation plans and any similar computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates.

12.1.5 Record Retention Requirements, Generally

(A) Unless otherwise specified by this Contract or by state or federal law, the Contractor shall keep all documents and reports required by this Contract for a period of 6 years. Such documents include, but are not limited to, the attestation forms required by Article 6.3.2, Contractor's policies and procedures, Contractor's member handbooks, and copies of reports required by the Department.

(B) The Contractor shall retain, and shall require its Subcontractors to retain Enrollee Grievance and Appeal records, base data, MLR reports, and the data, information and documentation specified in 42 CFR sections 468.604, 438.606, 438.608, 438.610 for a period of no less than 10 years.

12.2 Additional Reporting Requirements

12.2.1 Enrollment, Cost and Utilization Reports

(A) The Contractor shall submit an audited financial report to the Department by October 31st of each year. The audit shall be conducted in accordance with generally accepted accounting

principles and generally accepted auditing standards. The financial report shall be in a format designated by the Department.

(B) The Contract shall submit an enrollment, cost and utilization report in an format designated by the Department. The Contractor shall submit the report to the Department two times per year, as follows:

(1) May 1 for the preceding six month reporting period (July through December).

(2) November 1 for the preceding 12 month reporting period (July through June).

(C) The Contractor may request, in writing, an extension of the due date up to 30 days beyond the required due date. The Department shall approve or deny the extension request within seven calendar days of receiving the request.

12.2.2 Semi-Annual Reports

(A) The following semi-annual reports are due May 1 for the preceding six month reporting period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June):

(1) The Grievance and Appeals reports required by Article 8.7.1 of this Contract.

(2) The state requires the Contractor submit semi-annual reports summarizing information on corrective actions taken on physicians who have been identified by the Contractor as exhibiting aberrant physician behavior.

12.2.3 Reporting of Abortions, Sterilizations, and Hysterectomies

(A) On November 1 of each year, the Contractor shall submit to the Department the following information:

(1) An excel spreadsheet containing the following information for all abortions, hysterectomies, and sterilizations performed during the prior fiscal year:

(i) client name

(ii) Medicaid ID number

(iii) procedure code

(iv) date of service

(2) Consent forms for all abortions, hysterectomies, and sterilizations performed during the prior fiscal year;

(3) The medical records for all abortions performed during the prior fiscal year.

(B) The Department shall evaluate the documentation requested under Article 12.2.3 and may require medical record submission. The Contractor agrees to provide the additional documentation to the Department in the timeframes required by the Department.

12.2.4 Provider Network Reports

The Contractor shall submit a monthly electronic file of its Network Provider network that meets the Department's provider file specifications and data element requirements to the Department.

12.2.5 Case Management Reports

The Contractor shall submit annual case management reports no later than August 1 of each year for the preceding fiscal year.

12.2.6 PS&R Reporting

(A) In accordance with the Utah State Plan Attachment 4.19-B, page 1, incorporated into Utah Administrative R414-1-5, by reference, the Contractor shall provide, upon a Provider's request, a Provider Statistical and Reimbursement (PS&R) report.

(B) The PS&R report shall include statistical data including total covered charges, units, and reimbursement (including outpatient supplemental payments) by fiscal period.

(C) The Contractor shall provide the report within 30 days of the request.

12.2.7 Development of New Reports

The Department may request other reports deemed necessary to the Department to assess areas including, but not limited to, access and timeliness or quality of care. The Contractor agrees to submit any report requested by the Department within the time frames specified by the Department.

12.2.8 Data Collection

(A) By July 1st of each year, the Contractor shall provide the following information to the Department, in a Department specified format:

(1) enrollment and disenrollment data;

(2) Enrollee Grievance and Appeal logs;

(3) Provider complaint and Appeal logs;

(4) the results of any Enrollee or Provider satisfaction survey conducted by the Contractor;

(5) performance on required quality measures;

(6) medical management committee reports and minutes;

(7) the Contractor's annual quality improvement plan;

(8) audited financial and Encounter Data;

(9) the MLR summary reports;

(10) customer service performance data; and

(11) LTSS data .

12.2.9 Hospital Reporting

(A) In accordance with Utah Code §26-36b-204(4), the Contractor shall submit a report to the Department for the prior fiscal year the following data in a format designated by the Department:

(1) for the traditional Medicaid population, for each private hospital, state teaching hospital, state teaching hospital and non-state government hospital provider:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

12.2.10 Parties in Interest

(A) The Contractor shall report to the Department, and upon request, to the Secretary of the Department of Health and Human Services, the Inspector General of the Department of Health and Human Services, and the Comptroller General a descriptions of transactions between the Contractor and a party in interest as defined by Section 1318(b) of the Public Health Services Act, including the following transactions:

(1) Any sale or exchange, or leasing of any property between the Contractor and such a party;

(2) Any furnishing for consideration of goods, services, (including management services)

or facilities between the Contractor and such party, but not including salaraies paid to employees for services provided in the normal course of their employment; and

(3) Any lending of money or other extension of credit between the Contractor and such a party.

12.3 Encounter Data

12.3.1 Encounter Data, General Requirements

(A) In accordance with Section 1903(m)(2)(A)(xi) of the Social Security Act, the Contractor agrees to maintain sufficient patient Encounter Data to identify the Provider who delivers Covered Services to Enrollees.

(B) The Contractor shall transmit data to the Department using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR 162.1101 and 162.1102.

(C) The Contractor shall transmit and submit all data to the Department in accordance with the Department's Encounter Records 837 Institutional Guide and the 837 Professional Companion Guide, as amended.

(D) The Contractor shall submit Encounter Data at least once per calendar month. The Encounter Data shall represent all Encounter Claim types (medical and institutional) received and adjudicated by the Contractor the previous month.

(E) The Department will edit Encounter Data in accordance with the 837 companion guide. Encounters with incomplete data or incorrect codes will be rejected.

(F) The Department will notify the Contractor of the status of rejected Encounter Data by sending a 277 Health Care Claim Status Response Transaction to the Contractor. The Contractor shall be responsible for reviewing 277 transactions and taking appropriate action when necessary.

(G) The Contractor shall submit corrections to all rejected encounters within 45 days of the date the Department sends notice that the Encounter is rejected.

(H) The Contractor shall submit Encounter Data for all services rendered to Medicaid Enrollees under this Contract, including Encounters where the Contractor determined no liability exists. The Contractor shall submit Encounter Data even if the Contractor did not make any payment for a Claim, including Claims for services to Medicaid enrollees provided under a Subcontract, capitation or special arrangement with another facility or program. The Contractor shall submit Encounter Data for all services provided under this Contract to Medicaid Enrollees who also have Medicare coverage, if a claim was submitted to the Contractor.

(I) If the Contractor discovers that services and/or costs of Excluded Providers have been

included in the Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter Data.

12.3.2 Non-Encounter Data

(A) The Contractor shall submit to the Department, no later than 60 days after the end of each quarter a "Non-Encounter" data report. The report shall be in a Department-specified format. The Contractor shall follow the Department's instructions in filling out the report and shall not change the format of the report.

(B) With the exception of the information regarding drug rebates, the submission of all other Non-Encounter data is voluntary and it the Contractor's responsibility to provide whatever data the Contractor deems relevant.

12.4 Disallowance of Claims

12.4.1 Procedures for Incorrectly Paid Claims

(A) The Contractor shall take reasonable action to collect any incorrectly paid claim from the Provider within 12 months of the date of discovery of the incorrectly paid claim. Incorrectly paid claims can include but are not limited to claims which where duplicative, overpaid, or disallowed.

(B) The Contractor shall reverse the Encounter(s) for the incorrectly paid claims within sixty (60) days of the earlier of (1) the date of discovery of an incorrectly paid claim or (2) the date of the notice of the disallowance of the incorrectly paid claim. The Contractor shall correct any Encounter(s) for any incorrectly paid claim regardless of whether the Contractor is successful in collecting the payment from the Provider.

(C) Failure to properly reverse or adjust Encounter(s) will result in sanctions allowed by Article 14.

(D) The Contractor shall make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

(1) the Provider has submitted a Claim for the date of service within 12 months of the date of service;

(2) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had a primary insurance that should have paid on the Claim;

(3) the Provider can show, through EOBs or other sufficient evidence that the primary insurance was either not in effect or will not cover the billed service; and

(4) absent the coordination of benefits issues or the timely filing issues, the Claim is

otherwise payable.

12.5 Medical Loss Ratio

12.5.1 Medical Loss Ratio, Generally

(A) Annually, the Contractor shall calculate and report to the Department an MLR consistent with the MLR standards described in this Article 12.5.

(B) The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract unless the Department requires separate reporting and a separate MLR calculation for specific populations.

12.5.2 Medical Loss Ratio, Calculations

(A) The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(d)-(f).

(B) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(C) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

(D) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(E) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(F) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

12.5.3 Medical Loss Ratio, Credibility Adjustment

(A) The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

(B) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department.

(C) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(D) If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

12.5.4 Medical Loss Ratio, Reporting

(A) The Contractor shall submit a MLR report to the Department that includes, for each MLR reporting year: total incurred claims, expenditures on quality improving activities, expenditures related to activities compliant with program integrity requirements, non-claims costs, premium revenue, taxes, licensing fees, regulatory fees, methodology(ies) for allocation of expenditures, any credibility adjustment applied, the calculated MLR, any remittance owed to the Department (if applicable), a comparison of the information reported with the audited financial report, a description of the aggregation method used to calculate total incurred claims, and the number of member months.

(B) The Contractor shall submit the MLR report in a Department specified format no later than March 1st of each year. The Contractor's first report shall be due March 1, 2019.

(C) The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(D) In any instance where the Department makes a retroactive change to the Capitation Payments for a MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and submit a new MLR report meeting the applicable requirements.

(E) The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

12.6 Data Submission and Certification

12.6.1 Data Submission

(A) The Contractor shall submit the following data to the Department which is subject to the certification requirements found in 12.6.2:

(1) Encounter Data in the form and manner described in 42 CFR 438.818 and this Contract;

(2) data on the basis of which the Department certifies the actuarial soundness of

Capitation Rates to the Contractor under 42 CFR 438.4, including base data described in 42 CFR 438.5(c) that is generated by the Contractor;

(3) data on the basis of which the Department determines the compliance of the Contractor with the MLR requirement described in this Contract at 42 CFR 438.8;

(4) data on the basis of which the Department determines that the Contractor has made adequate provision against the risk of insolvency as required under this Contract and 42 CFR 438.116;

(5) Documentation described in 42 CFR 438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR 438.206;

(6) Information on ownership and control described in this Contract, 42 CFR 455.104 and 42 CFR 438.230; and

(7) the annual report of Overpayment recoveries as required by 42 CFR 438.608(d)(3).

(B) The Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's obligations under 42 CFR Part 438 as required by the Department or the Secretary of Health and Human Services.

12.6.2 Data Certification

(A) The individual who submits data, documentation or information described in Article 12.6.1 to the Department shall provide a certification, concurrently with the submission, which attests, based on the individual's best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.

(B) The data, documentation, or information required by 12.6.1 shall be certified by:

(1) The Contractor's Chief Executive Officer (CEO);

(2) The Contractor's Chief Financial Officer (CFO); or

(3) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

Article 13 Compliance and Monitoring

13.1 Audits

13.1.1 Inspection and Audit of Financial Records

(A) The Department and the federal government may inspect and audit any books and/or records of the Contractor or its Network Providers that pertain to:

(1) the ability of the Contractor to bear the risk of potential financial losses, or

(2) to services performed or determinations of amounts payable under the Contract, or

(3) for any other audit allowed by state or federal law.

(B) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law any of the Contractor's records that may reasonably be requested to conduct the audit.

(C) The Contractor shall, in accordance with 45 CFR 74.48 (and except for contracts less than the simplified acquisition threshold), allow the HHS awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

13.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other client data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

13.1.3 Information to Determine Allowable Costs

(A) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, all reasonable and related financial, statistical, clinical or other information needed for the

determination of allowable costs to the Medicaid program for "related party/home office" transactions, as defined by CMS Manual 15-1.

(B) The records described in Article 13.1.3(A) shall be made available in Salt Lake City, Utah or the Contractor shall pay the increased cost of auditing at an out-of-state location. The increased costs shall include round-trip travel and two days of lodging and per diem. Additional travel costs of the out-of-state audit shall be shared equally by the Contractor and the Department.

13.1.4 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, Fraud-related data, Abuse-related data, patient outcome data, and cost utilization data, which shall include patient profiles, exception reports, etc.

(B) The Contractor shall provide all data required by the Department, the federal government, independent quality review examiners, and other Utah state agencies allowed to conduct such audits.

13.2 Department and Contractor Quality Control

13.2.1 Quality Improvement Reports

(A) Annually, the Contractor shall submit to the Department the following documents:

(1) the Contractor's quality improvement program description for the current State Fiscal Year or calendar year,

(2) the Contractor's quality improvement work plan for the current State Fiscal Year or calendar year, and

(3) the Contractor's quality improvement work plan evaluation for the previous State Fiscal Year or calendar year.

(B) These reports shall be in a format developed by the Department and be signed by the Contractor.

(C) The reports listed in Article 13.2.1 shall be due on August 31 of each year.

13.3 Utah Office of the Inspector General

13.3.1 General Requirements

(A) The Contractor shall cooperate with the Utah OIG in any performance or financial audit Medicaid funds received by the Contractor as allowed by Utah Code Ann. §63J-4a-202(2).

(1) Records requested by the Utah OIG must be provided within 30 days in accordance with Utah Administrative Code R367-1-7.

(2) The Utah OIG shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual criteria published by McKesson Corporation, or another suitable industry standard substitute in accordance with Utah Administrative Code R367-1-7(3)(b).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. §63J-4a-301.

(C) The Contractor and its employees shall cooperate with the Utah OIG with respect to an audit or investigation as required by Utah Code Ann. §§63J-4a-302, 303.

(D) In accordance with Utah Code Ann. §63J-4a-304, the Contractor and its employees shall not interfere with a Utah OIG audit or investigation.

(E) The Contractor shall comply with all subpoenas from the Utah OIG that are properly issued pursuant to Utah Code Ann. §63J-4a-401.

(F) The Contractor shall allow the Utah OIG to conduct announced or unannounced site visits in accordance with 42 CFR 455.432.

Article 14 Corrective Action and Sanctions

14.1 Corrective Action Plans

14.1.1 Corrective Action Plans, Generally

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department may impose a corrective action plan to cure the Contractor's non-compliance.

(B) At the Department's discretion, the corrective action plan may be developed by the Department or the Contractor.

14.1.2 Department-Issued Corrective Action Plan

(A) The Department may develop a corrective action plan which the Department shall provide to the Contractor, in writing.

(B) The Contractor agrees to comply with the terms of a Department-issued corrective action

plan and to complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan. If the Contractor fails to satisfactorily complete the Department's corrective action plan, the Department may assess liquidated damages in accordance with Article 14.3 of this Contract.

(C) If the Contractor disagrees with the Department's corrective action plan, the Contractor may file a Request for a State fair hearing within 30 days of receipt of the Department's corrective action plan.

14.1.3 Contractor Generated Corrective Action Plan

(A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.

(B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.

(C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 days of receipt. In the event that the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised. The corrective action plan submitted by the Contractor shall be deemed approved by the Department if the Department fails to respond to the Contractor within 20 days of receipt of the Contractor's corrective action plan.

(D) The Contractor agrees to comply with the terms of a Department approved corrective action plan and to complete all required actions within the required timeframes. If the Contractor fails to satisfactorily complete the Department's corrective Action Plan, the Department may assess liquidated damages in accordance with Article 14.3 of this Contract.

14.1.4 Notice of Non-Compliance

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and time frame in which the Contractor's non-compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 days to cure its non-compliance. However, the Department may shorten the 30 day time period in the event that a delay would endanger an Enrollee's health or the timeframe must be shortened in order for the Department and the Contractor to meet federal guidelines.

(B) If the Contractor fails to cure the non-compliance as ordered by the Department and within the timeframes designated by the Department, the Department may, at its discretion, impose any

or all of the following sanctions:

(1) Suspension of the Contractor's Capitation Payment;

(2) Assessment of Liquidated Damages;

(3) Assessment of Civil Monetary Penalties; and/or

(4) Imposition of any other sanction allowed by federal and state law.

(C) The Department agrees that it shall not, for an individual event of the Contractor's non-compliance, impose both liquidated damages and the suspension of the Contractor's Capitation Payment. The Department may choose to either suspend the capitation payment or impose liquidated damages.

(D) The Department's imposition of any of the Sanctions described in 15.1.4(B) is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in 15.1.4(B) in no way limits additional remedies, at law or at equity, available to the Department due to the Contractor's Breach of this Contract.

(E) The Department may impose any additional sanctions on the Contractor provided for under state statutes or regulations to address non-compliance.

14.2 Capitation Payment Suspension

14.2.1 Capitation Payment Suspension, Generally

(A) The Department may suspend Contractor's Capitation Payment in the event that the Contractor fails to comply with any provision of this Contract.

(B) The Department may suspend the Contractor's Capitation Payment for any failure to submit or comply with a corrective action plan within the timeframes required by the Department.

14.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 days.

(B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments,

the Contractor may request a State fair hearing within 30 days of receipt of the Department's notice of intent to suspend the Capitation Payments. The Department may continue to withhold Capitation Payments through the duration of the State fair hearing, unless ordered by the State fair hearing officer to release the Capitation Payments.

14.3 Liquidated Damages

14.3.1 Liquidated Damages, Generally

(A) If the Contractor fails to perform or does not perform in a timely manner provisions under this Contract, damages to the Department may result. The parties agree that the damages from breach of this Contract may be incapable or very difficult of accurate estimation.

(B) Should the Department chose to impose liquidated damages, the Parties agree that the following damages provisions represent a reasonable estimation of the damages that would be suffered by the Department due to the Contractor's failure to perform. Such damages to the Department would include additional costs of inspection and oversight incurred by the Department due to Contractor's non-performance or late performance of any provision of this Contract.

(C) At its discretion, the Department may withhold liquidated damages from the Department's Capitation Payment to the Contractor.

(D) If the Department chooses to impose liquidated damages, the Department shall provide the Contractor with written notice of its intent to impose liquidated damages.

(E) If the Contractor disagrees with the reason for the imposition of liquidated damages, the Contractor may request a State fair hearing within 30 days of receipt of the Department's notice of intent to impose liquidated damages. The Department may impose liquidated damages through the duration of the State fair hearing unless the State fair hearing officer orders that the imposition of liquidated damages should be discontinued throughout the State fair hearing process.

(F) Each category of liquidated damages found in Article 14.3.2 and Article 14.3.3 is exclusive, meaning that for any individual event of non-compliance by the Contractor the Department may only assert one category of liquidated damages. For example, if the Department imposes liquidated damages of $500 per calendar day for failure to comply with a corrective action plan, it may not also impose for the same event liquidated damages of $300 per calendar day for failure to submit documents to the Department. Furthermore, each imposition of liquidated damages must be based on actual failure of the Contractor to comply with the terms of this Contract, and no event of noncompliance may be extrapolated to other unsubstantiated claims of noncompliance.

(G) In no event will the Contractor's cumulative liability under Article 14.3 be more than $1,000,000 per calendar year.

(H) The Department's ability to assess liquidated damages under this Section 14.3 is limited to the Contractor. In no event will liquidated damages under this Article 14.3 be assessed against the Contractor's parent company or any other affiliate of the Contractor.

(I) In no event may liquidated damages be retroactively assessed against the Contractor for failures to comply with the terms of this Contract that occurred more than one year prior to the discovery of the failures except in cases involving fraud, waste, and abuse.

14.3.2 Liquidated Damages, Per Day Amounts

(A) The Department may assess the following damages against the Contractor for each date beyond the deadline that the Contractor was required to take the following actions:

(1) $300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;

(2) $400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;

(3) $1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 12.3)or the Post Adjudication Pharmacy file (as required by Article 4.14.8);

(4) $1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 12.3) or Post Adjudication History file (as required under Article 4.14.8);

(5) $2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the time frames established under Attachment E.

(6) $500 per calendar day the Contractor fails to submit or comply with corrective action plan;

(7) $500 per calendar day that the Contractor fails to provide audit access as required by Article 13.1;

(8) $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 intervention;

(9) $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;

(10) $500 per calendar day for other violation of 42 CFR 438 which requires Department intervention or supervision.

14.3.3 Additional Liquidated Damages

(A) The Department may assess the following liquidated damages:

(1) $1,000 per each occurrence that the Contractor fails to properly credential a Network Provider as required by Article 5.3 of this Contract (including a failure to search the LEIE database, or has provider agreements that do not meet the requirements of Article 5.3) and such failure to credential requires Department intervention or supervision.

(2) $1,000 per each occurrence where the Contractor fails to provide an Enrollee access to Covered Services as required by this Contract and such failure requires Department intervention or supervision.

14.4 Sanctions Allowed by Federal Law

14.4.1 Reasons for Imposition of Intermediate Sanctions

(A) In accordance with 42 CFR 438.700, the Department may impose intermediate sanctions when the Contractor acts or fails to act as follows:

(1) Fails substantially to provide Medically Necessary services that the Contractor is required to provide, under law or under this Contract with the Department, to an Enrollee covered under this Contract;

(2) Imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(3) Acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a client, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future medical services;

(4) Misrepresents or falsifies information that it furnishes to CMS or the Department;

(5) Misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or health care provider;

(6) Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210.

(7) Has distributed directly or indirectly through any agent or independent contractor marketing materials that have not been approved by the Department or that contains false or misleading information.

(8) Prohibits or restricts a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient for any of the reasons listed in 42 CFR 438.102(a)(1).

(9) Has violated any of the other applicable requirements of Section 1903(m) or Section 1932 of the Social Security Act and its Implementing Regulations.

(B) In the event that the Contractor fails to safeguard Enrollee Protected Health Information the Contractor shall be subject to sanctions imposed by CMS pursuant to HIPAA and HITECH.

14.4.2 Types of Intermediate Sanctions

(A) The Department may impose any or all of the following intermediate sanctions:

(1) Civil monetary penalties in the amounts specified in 42 CFR 438.704.

(2) Appointment of temporary management of the Contractor as provided in 42 CFR 438.706 and this Contract.

(3) Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the effective date of sanction.

(5) Suspension of payment for clients 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.

(B) The Department may impose additional sanctions provided for under state statutes or rules to address noncompliance.

14.4.3 Notice of Sanction

(A) In accordance with 42 CFR 438.710, the Department shall provide the Contractor with timely written notice before imposing any of the intermediate sanctions specified in Article 14.4.2. The notice shall explain the basis and the nature of the sanction.

(B) The Contractor has 30 days to provide a written response to the Department.

(C) If the Contractor disagrees with the imposition of any of the sanctions specified in Article 14.4.2, the Contractor may request a State fair hearing. The Department may continue to impose the Sanction through the duration of the State fair hearing unless the hearing officer orders otherwise.

14.4.4 Discretionary Imposition of Temporary Management

(A) Pursuant to 42 CFR 438.706, the Department may impose temporary management of the administration of the Contractor's Medicaid operations only if it finds (through onsite survey, Enrollee or other complaints, financial status, or any other source) that:

(1) There is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 CFR 438.700 or that is contrary to any requirements of Section 1903(m) and Section 1932 of the Social Security Act;

(2) There is substantial risk to the Enrollee's health; or

(3) The sanction is necessary to ensure the health of the Contractor's Enrollees while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the Contractor.

14.4.5 Required Imposition of Temporary Management

(A) In accordance with 42 CFR 438.706, the Department shall impose temporary management of the administration of the Contractor's Medicaid operations (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act.

(B) The Department shall grant Enrollees the right to terminate enrollment without cause and shall notify Enrollees of their right to terminate Enrollment.

14.4.6 Hearing on Temporary Management

The Department may not delay imposition of temporary management of the administration of the Contractor's Medicaid operations to provide a hearing before imposing this sanction.

14.4.7 Duration of Temporary Management

The Department may not terminate temporary management of the administration of the Contractor's Medicaid operations until it determines that the Contractor can ensure that the sanctioned behavior shall not recur.

14.4.8 Sanctions Imposed by CMS: Denial of Payment

The Department may recommend that CMS deny payments to new Enrollees in accordance with 42 CFR 438.730.

Article 15 Termination of the Contract

15.1 Automatic and Without Cause Termination

15.1.1 Automatic Termination

This Contract shall automatically terminate on December 31, 2017.

15.1.2 Termination Without Cause

(A) The Contractor may terminate this Contract without cause by giving the Department written notice of termination at least 60 days prior to the termination date. The termination notice must be on the first working day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 days written notice.

15.1.3 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services and related administrative functions required by this Contract until midnight of the last calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or thirty days following termination, whichever occurs first.

(B) Upon any termination of this Contract the Contractor shall promptly supply to the Department any information it requests regarding paid and unpaid Claims.

(C) If the Contractor one of its Network Providers, or other subcontractor becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor, the Network Provider, or the Subcontractor.

15.2 Termination of Contract With Cause

15.2.1 Termination of Contract With Cause, Generally

(A) In accordance with 42 CFR 438.708, the Department may terminate this Contract and enroll the Contractor's Enrollees in other MCOs or PCCMs or provide their Medicaid benefits through other options included in the State Plan, if the Department determines that the Contractor has failed to:

(1) Carry out the substantive terms of this Contract; or

(2) Meet the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act.

15.2.2 Pre-Termination Hearing

(A) In accordance with 42 CFR 738.710, before terminating the Contract pursuant to Section 16.2.1 of this Contract, the Department must provide the Contractor with a pre-termination hearing. The Department shall:

(1) Give the Contractor written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;

(2) After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of the termination; and

(3) For an affirming decision, give Enrollees notice of termination and information consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of the termination.

(B) In accordance with 42 CFR 438.722, after the Department notifies the Contractor that it intends to terminate the Contract, the Department may give Enrollees written notice of the Department's intent to terminate the Contract and may allow Enrollees to disenroll immediately, without cause.

15.2.3 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

15.3 Close Out Provisions

15.3.1 Close Out Provisions

(A) Notwithstanding any provision found in Attachment A, in the event of termination of this Contract, the Contractor shall complete any and all duties required by this Contract including, but not limited to the following:

(1) processing and paying any Claims generated during the lifetime of this Contract including completing appeals by both Providers and/or Enrollees and any monetary reconciliations;

(2) providing the Department with complete and accurate Encounter Data for all Encounters generated during the lifetime of this Contract;

(3) providing the Department with reports as required by this Contract;

(4) complying with any audit requests.

(B) Failure of the Contractor to comply with the provisions found in this Article 15.3 shall be deemed a breach of Contract and the Department may exercise any remedy available under this Contract or by operation of law. The Department shall give the Contractor notice of any activities not completed after termination and shall give the Contractor an opportunity to cure any breaches prior to declaring a breach of the Contract.

Article 16 Miscellaneous Provisions

16.1 Additional Provisions

16.1.1 Integration

This Contract and all attachments hereto, contain the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof. Notwithstanding Attachment A, General Provisions, Article III, item 27, if there is a conflict between this Attachment B, Special Provisions, and the Attachment A, General Provisions, then this Attachment B shall control.

16.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

16.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

16.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

16.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

16.1.6 Continuation of Services During Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly Capitation Payments to the Contractor.

16.1.7 Surveys

All surveys required under this Contract shall be funded by the Contractor unless another source agrees to fund the survey.

16.1.8 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's policies and procedures in Provider Manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its Network Providers comply with the policies and procedures in effect at the time when services are rendered.

(B) The Contractor shall comply with all appropriate and applicable state and federal rules and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

16.1.9 Solvency Standards

(A) Unless exempt, the Contractor shall comply with 42 CFR 438.116(a), and provide assurances satisfactory to the Department showing that is provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the Contractor's debts if the Contractor becomes insolvent.

(B) Unless exempt, the Contractor agrees to meet the solvency standards required by 42 CFR 438.116(b)(1).

16.1.10 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

16.1.11 ACA Health Insurer Fee

(A) The Contractor is responsible for paying the annual Health Insurer Fee.

(B) The monthly Capitation Rates found in Attachment F include the Health Insurer Fee as well as any associated state and federal taxes arising out of the Health Insurer Fee. The Department shall incorporate funding for the Health Insurer Fee into the Capitation Rates on a prospective basis. The Capitation Rates shall be adjusted as needed each year to ensure actuarial soundness. During the Capitation Rate adjustment the Department shall:

> (1) reconcile the new Capitation Rate by the amounts of the Health Insurer Fee incorporated into the previous year's Capitation Rate which the Department has determined through actuarial certification has been overpaid during the previous fiscal year.

(C) The Department shall fund the Health Insurer Fee up to the amount appropriated by the Utah state legislature. The Department may request an appropriation from the Utah legislature for additional funding in the event the Department determines through actuarial certification that the amount appropriated by the Utah legislature does not adequately cover incorporation of the Health Insurer Fee into the new Capitation Rates.

(D) By September 30 of each year, the Contractor shall provide to the Department its Health Insurer Fee invoice relating to the premiums paid to the Contractor under this contract. The Contractor shall also provide any additional supporting documentation relating to the Health Insurer Fee requested by the Department.

(E) The Contractor agrees not to pursue legal action whatsoever against the Department or its officers, employees, or agents with respect to the Health Insurer Fee.

16.2 Access to the Controlled Substance Database

16.2.1 Application for Access

(A) In accordance with Utah Code Ann. §58-37f-301(2)(e), the Contractor may make a written application to the Department for authorization for its employees to have access to the Controlled Substance Database.

(B) When designating an employee as needing access to the Controlled Substance Database the Contractor shall certify that the person is employed by the Contractor.

16.2.2 Criminal Background Report

(A) The Contractor shall conduct a criminal background report for each employee which the Contractor is applying for access to the Controlled Substance Database.

(B) The criminal background report shall be issued by the Utah Bureau of Criminal Identification and shall be provided to the Department as part of the Contractor's application for employee access to the Controlled Substance Database.

(C) The Department shall approve access to any employee whose criminal background report shows that the employee has not been arrested, charged, or convicted of any misdemeanor or felony within the last ten years. If the criminal background report shows that an applicant has been convicted of any misdemeanor or felony within the past ten years, then the Department of and DOPL must each approve authorization of the Contractor's employee based upon the nature of the criminal offense that resulted in the conviction and the criteria set forth in Utah Administrative Code R156-1-302 and R156-1-102(2) and (16).

(D) The Contractor shall conduct the criminal background report at its own cost.

16.2.3 Employee Compliance with State Law

(A) Each employee who is granted access to the Controlled Substance Database shall comply with the Utah Government Records Access and Management Act ("GRAMA"), Utah Code Ann §63G-2-101, *et seq.* and the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, *et seq.* Each employee must comply with the following:

> (1) All information in the database falls within the definition of "record" in the GRAMA. All records in the database are records of DOPL. Pursuant to the provisions of GRAMA, records in the database are not public and access to those records is governed by the provisions of the Controlled Substance Database statute. (See Utah Code Ann. §§ 63G-2-201(3)(b); 63G-2-201(6)(a); and 58-37f-101 through 801.)

(B) The Contractor shall be responsible for ensuring that its employees who have access to the Controlled Substance Database understand their compliance responsibilities as described in Article 16.2.3(A) and shall provide any necessary training to their employees.

16.2.4 Limitation of Database Searches

Each employee who is authorized by the Department to access the Controlled Substance Database shall limit their searches of the Controlled Substance database to current Enrollees who are suspected of improperly obtaining or providing a controlled substance.

16.2.5 Search Submitted Directly to the Department of Commerce

(A) Employees who have been given access to the Controlled Substance Database shall submit any request for database information directly to the Department of Commerce. The requests shall be in writing via letter, fax, or email.

(B) The Department of Commerce shall review the request for database information and may request additional information. If the request for database information is satisfactory, the Department of Commerce will conduct the database search, download the database information,

16.2.6 Employee Acknowledgement

(A) Any employee who has been authorized by the Department to access the Controlled Substance Database shall be required to sign an acknowledgement regarding their access as required by the Department and the Utah Department of Commerce prior to gaining access to the Database. The acknowledgement shall include the language found in Article 16.2.7 which may be subject to change.

16.2.7 Language of Employee Acknowledgement

As a managed care organization (MCO) employee authorized to request information from the Utah Controlled Substance Database, I understand and acknowledge that I will comply with the following statutes:

(1) Utah Code Ann. § 58-37f-301(2)(f) provides that the database manager shall provide database information:

(a) in accordance with the written agreement entered into with the Department, and the Department of Health, authorized employees of a MCO, as defined in 42 C.F.R. 438, if:

(i) the MCO contracts with the Department of Health under the provisions of Section 26-18-405, and the contract includes provisions that:

(A) require an MCO employee who will have access to information from the database to submit to a criminal background check; and

(B) limit the authorized employee of the MCO to requesting either the Division or the Department of Health to conduct a search of the database regarding a specific Medicaid enrollee and to report the results of the search to the authorized employee; and

(ii) the information is requested by an authorized employee of the MCO in relation to a person who is enrolled in the Medicaid program with the managed care organization, and the MCO suspects the person may be improperly obtaining or providing a controlled substance;

(2) Utah Code Ann. § 58-37f-601(1), which provides as follows:

> Any person who knowingly and intentionally releases any information in the database or knowingly and intentionally releases any information obtained from other state or federal prescription monitoring programs by means of the database in violation of the limitations under Part 3, Access, is guilty of a third degree felony.
>
> (3) Utah Code Ann. § 58-37f-601(2), which provides as follows:
>
> Any person who obtains or attempts to obtain information from the database or from any other state or federal prescription monitoring programs by means of the database by misrepresentation or fraud is guilty of a third degree felony.
>
> (4) Utah Code Ann. § 58-37f-601(3), which provides, in part, as follows:
>
> (a) . . . a person may not knowingly and intentionally use, release, publish, or otherwise make available to any other person or entity any information obtained from the database or from any other state or federal prescription monitoring programs by means of the database for any purpose other than those specified in Part 3, Access.
>
> (b) Each separate violation of this Subsection (3) is a third degree felony and is also subject to a civil penalty not to exceed $5,000.

As an authorized MCO employee, I shall strictly limit my investigation and my request for database information to subjects who: (1) are enrolled in the Medicaid program with my managed care organization, (2) are suspected of improperly obtaining or providing a controlled substance, as specifically set forth in Utah Code Ann. § 58-37f-301(2)(e).

As an authorized MCO employee, I shall not release any database information to any unauthorized person, including persons within my MCO who are not authorized to view the information, employees of the Department of Health, or any law enforcement or prosecutorial agency. I acknowledge that database information shall not be used as evidence in any administrative, civil, or criminal litigation.

16.2.8 Employee Termination

The Contractor shall immediately notify the Department and the Utah Department of Commerce when any employee who has been granted access to the Controlled Substance database has terminated employment with the Contractor or who no longer requires access to the Controlled Substance Database as part of their job duties.

16.2.9 Termination of Access

(A) The Department or the Utah Department of Commerce may unilaterally terminate access of any authorized employee to the Controlled Substance Database at any time if the Department or DOPL determines that the authorized employee has violated any of the provisions set forth in the access agreement described in Article 16.2.5, any statute, or any administrative rule governing the Controlled Substance Database.

(B) Any decision to terminate access to the Controlled Substance Database may be reviewed by the Executive Director of the Utah Department of Commerce.

16.2.10 Hold Harmless

The Contractor shall hold the Department harmless from and against any claims, damages, causes of action, losses, and expenses that arise out of any violation of the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, *et seq.* or its implementing regulations committed by the Contractor, its employees, or subcontractors.

16.3 Data Security Provisions

16.3.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

16.3.2 Network Security

(A) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall at all times maintain network security that at minimum, includes network firewall provisioning, intrusion detection and regular third party penetration testing.

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to one of the following:

(1) Those standards which the State of Utah applies to its own network as found at http://www.dts.utah.gov;

(2) Current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) Any industry accepted standards that is comparable to those described in

16.3.2(B)(1) or (2).

16.3.3 Data Security

(A) The Contractor shall protect and maintain the security of Confidential Data with protection that conforms to one of the following:

(1) Standards that are at least as good as or better than that maintained by the State of Utah found at http://www.dts.utah.gov;

(2) Current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) Any industry accepted standards that is comparable to those described in 16.3.3(A)(1) or (2).

(B) The Contractor shall develop and use appropriate administrative, technical and physical security measures to preserve the confidentiality and integrity of all electronically maintained or transmitted Confidential Data. These security measures include, but are not limited to, maintaining up-to-date anti-virus software, maintaining systems with current security updates, and controlled access to the physical location of the hardware itself.

16.3.4 Data Transmission

The Contractor shall ensure that any transmission or exchange of Confidential Data from the Contractor to the Department shall take place via secure means, such as HTTPS or FTPS.

16.3.5 Data Storage

(A) The Contractor shall ensure that any Confidential Data will be stored, processed, and maintained solely on designated target servers and that no Confidential Data at any time will be processed on or transferred to any unencrypted portable or laptop computing device or any unencrypted portable storage medium.

(B) The Contractor shall ensure that any Confidential Data that is stored, processed, or maintained on a laptop, portable computing device, cell phone, or portable storage device shall be encrypted using no less than 128 bit key.

16.3.6 Data Re-Use

The Contractor shall ensure that any and all Confidential Data exchanged shall be used expressly and solely for the purposes of fulfilling this Contract and other purposes as required or permitted by law. Confidential Data shall not be distributed, repurposed or shaped across other applications, environments, or business units of the Contractor. The Parties acknowledge and agree that Contractor may use and exchange Confidential Information for purposes related to

managing the healthcare needs of Enrollees, including quality improvement initiatives, health care operations, utilization management, and other Enrollee health management purposes.

16.3.7 Notification of Confidential Data Breach

The Contractor shall notify the Department when any Contractor system that may access, process, or store Confidential Data is subject to unintended access or disclosure. The Contractor shall notify the Department of such unintended access or disclosure within 48 hours of discovery of such access or disclosure.

16.3.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the Duty of Confidentiality found in Article 16.3.1 and the Confidential Data requirements found in Articles 16.3.2 through 16.3.7 to all Subcontractors used by the Contractor.

16.3.9 Access to State of Utah Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to any database maintained by the State of Utah or by the Department to whom the Department has given access.

(B) The Contractor shall notify the Department within two business days when an employee or subcontractor who has access to a database maintained by the Department or the State no longer requires access to the database.

(C) On a quarterly basis the Contractor shall provide to the Department a log of all employees who have access to a Department or State maintained database and in submitting that log to the Department, shall certify that the job duties of each employee named in the log requires that employee to have access to a Department-maintained database.

Attachment C – Covered Services

Article 1 Covered Services, Limitations, & Exclusions

1.1 Special Provisions

1.1.1 Medicaid Provider Manuals

The Contractor shall administer Covered Services in accordance with the Medicaid Provider Manuals. Medicaid Provider Manuals provide detailed information regarding Covered Services and are available to the Contractor on the Department's website.

1.1.2 Traditional Medicaid Enrollees

This Attachment C describes Covered Services, limitations and exclusions for Traditional Medicaid Enrollees.

1.2 Covered and Carved Out Services

1.2.1 Covered and Carved Out Services, Generally

(A) The Contractor shall cover all services and codes that Medicaid covers under the Medicaid State Plan except when the service is:

(1) specifically listed in this Contract as being "carved out" of this Contract;

(2) otherwise limited by this Contract; or

(3) limited by service limitations found in the State Plan.

(B) The Parties agree that the Coverage and Reimbursement Code Look Up Tool and the Department's Provider Manuals are the official listings of the specific services and codes Medicaid covers pursuant to the Medicaid State Plan. In the event of a conflict between the Coverage and Reimbursement Code Look Up Tool and the Department's Provider Manuals the Department retains the right to determine whether the codes are covered pursuant to the State Plan.

(C) The Department shall have the right to interpret the State Plan, Provider Manuals, Medicaid Information Bulletins and the Coverage and Reimbursement Code Look Up Tool.

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

(E) Medicaid services can only be limited through utilization criteria based on Medical Necessity.

1.2.2 Categories of Carved out Services

(A) The Contractor is not responsible to cover the following Medicaid State Plan or Waiver services. These services are "carved out" of this Contract:

(1) In general, dental services including orthodontics and anesthesia for dental services are carved out except as provided in Section 1.3.27 and Section 1.3.31.

(2) Targeted case management: The following codes are carved out except as provided in Section 1.3.25: T1017, T1023

(3) Ambulance transportation services

(4) Care in a Nursing facility, Intermediate Care Facility, or a Long Term Acute Care hospital when the prognosis indicates that a stay longer than 30 Days will be required (see Attachment B, Section 4.5)

(5) Waiver Services:

(i) Home and Community – Based Waiver Services For Individuals 65 or Older

(ii) Home and Community – Based Waiver Services For Individuals With Acquired Brain Injury Age 18 and Older

(iii) Community Supports Waiver Services For Individuals with Intellectual Disabilities or Other Related Conditions

(iv) Home and Community – Based Waiver Services For Individuals with Physical Disabilities

(v) Home and Community – Based Waiver Services - New Choices Waiver

(vi) Home and Community – Based Waiver Services For Technology Dependent, Medically Fragile Individuals

(vii) Autism Waiver Services

(6) Specialized mental health services. Treatment for mental health conditions is a covered service when done by a Primary Care Provider. Mental health conditions may be handled by the Contractor‘s Primary Care Providers or referred to the Enrollee’s Prepaid Mental Health Plan when more specialized services are required for the Enrollee. (See Attachment B, Section 4.10)

(7) Substance use disorder services are carved out except for the service(s) specified in Section 1.3.19.

(8) Specific classes of drugs: Transplant Immunosuppressive Drugs, Attention Deficit Hyperactivity Disorder Stimulant Drugs, Anti-psychotic Drugs, Anti-depressant Drugs, Anti-anxiety Drugs, Anti-convulsant Drugs, Hemophilia Drugs, and the following Substance Use Disorder Treatment Drugs and their associated generics (if any) indicated for the same uses:

(a) Vivitrol®
(b) Revia®
(c) Suboxone®
(d) Campral®
(e) Antabuse®

(9) Services provided under the hemophilia waiver (disease management waiver). Hemophilia drugs given as part of an inpatient facility stay are not carved out.

(10) Methadone maintenance treatment services

(11) Transportation

(12) Psychological evaluations and testing

(13) Any services performed at an Indian Health Services (IHS), tribal facility or an Urban Indian Facility (UIF)

(14) Early intervention services

(15) School-based skills development program services

(16) Chiropractic services

(17) Services performed at the Utah State Hospital

(18) Services performed at the Utah State Developmental Center

(19) Mental Health evaluations and psychological testing performed for physical health purposes including evaluations and testing performed prior to medical procedures, or for the purpose of diagnosing intellectual disabilities, developmental disorders, or related conditions. This does not include services described in Article 4.7.1 of Attachment B of this Contract.

(20) Apnea Monitors

1.2.3 Special Rules for Apnea Monitors and Oxygen Concentrators

The Contractor is responsible for payment of oxygen concentrators for Enrollees living in counties with mandatory enrollment in ACO health plans as specified in the service area section of Article 2 in Attachment B.

1.2.4 Special Rules for Enrollees dually eligible for Medicare Part D

The Contractor is not required to cover benzodiazepines or barbiturates for Enrollees who are dually eligible for Medicare Part D.

1.3 Categories of Covered Services,

1.3.1 Covered Services, General Requirements

This Attachment C lists broad categories of Covered Services.

1.3.2 Inpatient Hospital Services

Services furnished in a licensed, certified hospital are Covered Services.

1.3.3 Outpatient Hospital Services

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital are Covered Services.

1.3.4 Emergency Department Services

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

1.3.5 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are Covered Services.

1.3.6 General Preventative Services

Preventative services such as mammograms, Pap smears, and prostate exams are Covered Services.

1.3.7 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice are Covered Services.

(B) Covered Vision Services include, but are not limited to, the following:

(1) Eye examinations and care to identify and treat medical problems

(2) Eye refractions, examinations

(3) Laboratory work

(4) Lenses

(5) Eyeglass Frames

(6) Repair of Frames

(7) Repair or Replacement of Lenses

(8) Contact Lenses (when Medically Necessary)

(C) Eyeglasses including frames, lenses and contacts are Covered Services for CHEC Enrollees and pregnant women.

1.3.8 Laboratory and Radiology Services

(A) Professional and technical laboratory and X-ray services furnished by licensed and certified providers are Covered Services.

(B) All laboratory testing sites, including physician office labs, providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

(C) Those laboratories with certificates of waiver shall provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

1.3.9 Physical Therapy

(A) Treatment and services provided by a licensed physical therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

1.3.10 Occupational Therapy

(A) Treatment and services provided by a licensed occupational therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist.

(C) Necessary supplies and equipment shall be reviewed for medical necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Occupational Therapy services provided in the home are available only to Enrollees who are pregnant women or CHEC Enrollees.

1.3.11 Speech and Hearing Services

(A) Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss are Covered Services for Enrollees Eligible for CHEC.

(B) Speech and language services are Covered Services for Enrollees eligible for CHEC. For Enrollees who are not eligible for CHEC, speech and language services are not Covered Services unless provided as part of an acute inpatient hospital stay, as outpatient therapy in an acute hospital owned and operated by the acute hospital, or at a Federally Qualified Health Center.

(C) Audiology and hearing services including hearing aids and batteries are Covered Services for CHEC Enrollees.

(D) Speech augmentative communication devices (SACDs) are a Covered Service for CHEC Eligible Enrollees. SACDs are a Covered Service for Enrollees who are not eligible for CHEC if the SACD(s) is Medically Necessary.

1.3.12 Podiatry Services

(A) Services provided by a licensed podiatrist are Covered Services.

1.3.13 End Stage Renal Disease—Dialysis

(A) Treatment of end stage renal dialysis for kidney failure is a Covered Service. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.3.14 Home Health Services

(A) Home health services are defined as part-time intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound are Covered Services. Home Health Services are based on a physician’s order and plan of care.

(B) Home health care shall be rendered by a Medicare-certified Home Health Agency.

(C) The Contractor agrees to comply with all federal regulations regarding surety bonds. The Contractor agrees to contract with only Medicare-certified Home Health Agencies who carry a surety bond if federal regulations regarding this requirement are reinstated. The Department agrees to notify the Contractor if such federal regulations are reinstated.

(D) Personal care services as defined in the Department's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

1.3.15 Hospice Services

(A) Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are Covered Services. CHEC enrollees may elect to receive both palliative and aggressive care.

(B) Hospice care shall be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR or freestanding hospice facility, the Contractor is responsible for up to 30 days of hospice care.

1.3.16 Private Duty Nursing

(A) Services provided by licensed nurses for ventilator-dependent individuals in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home are Covered Services.

(B) Requests for continuous care shall be evaluated on a case by case basis and shall be approved by the Contractor.

1.3.17 Medical Supplies and Medical Equipment

(A) Medical Supplies and Medical Equipment are Covered Services which include any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but shall be ordered by a physician.

(B) Durable medical equipment (DME) which are considered Covered Services, includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies shall be provided by a DME supplier that has a surety bond. Necessary supplies and equipment shall be reviewed for medical necessity and follow the criteria of Utah Administrative Code R414-70, with the exception of criteria concerning long term care since long term care services are not covered under the Contract.

1.3.18 Abortions and Sterilizations

(A) Abortions are covered only under the following conditions specified in the Federal Hyde Amendment:

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(B) Sterilizations are Covered Services to the extent permitted by Federal and State law.

(C) Both abortions and sterilizations shall meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements shall be met regardless of whether Medicaid is primary or secondary payer.

1.3.19 Treatment for Substance Use

(A) Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

1.3.20 Organ Transplants

(A) The following transplantations are Covered Services for all Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article 4.9. Medical costs for the donor are only covered if the donor is Medicaid eligible.

1.3.21 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, freestanding ambulatory surgical centers and birthing centers.

1.3.22 Skilled Nursing Facility, Intermediate Care Facility and Long Term Acute Care Stays 30 Days or Less

(A) The Contractor shall provide as a Covered Service care for Enrollees in skilled nursing facilities, Intermediate Care Facilities and Long Term Acute Care (LTAC) hospitals requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less.

(B) When the prognosis of an Enrollee indicates that the stay shall be more than 30 days, the Contractor shall notify the Department and the facility of the prognosis determination and shall initiate disenrollment.

(C) Skilled nursing care is to be rendered in a facility which meets federal regulations of participation.

1.3.23 Services to CHEC Enrollees

(A) The Contractor shall provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

(B) The Contractor is not responsible for providing home and community-based services available through Utah's Home and Community-Based waiver programs.

(C) The Contractor shall provide the full early and periodic screening, diagnosis, and treatment services to all eligible CHEC Enrollees in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual.

(D) The Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules, including policies for Participating Providers to screen all members between six months and 72 months for blood lead levels. These policies and procedures shall emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC Enrollees.

1.3.24 Family Planning Services

(A) Family Planning Services are covered Services. Family Planning Services includes disseminating information, counseling, and treatments relating to family planning services.

(B) Family Planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law.

(C) Birth control services include information and instructions related to the following:

(1) Birth control pills;

(2) Norplant (removal only);

(3) Depo Provera;

(4) IUDs;

(5) Barrier methods including diaphragms, male and female condoms, and cervical caps;

(6) Vasectomy or tubal ligations;

(7) Nuvaring; and

(8) Office calls, examinations or counseling related to contraceptive devices.

1.3.25 High-Risk Prenatal Services

(A) The Contractor shall ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility.

(B) In the determination of the Provider and facility to which a high risk prenatal Enrollee shall be referred, care shall be taken to ensure that the Provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

(C) Enrollees who are pregnant shall be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not be moderate or high risk shall be evaluated for change in risk status throughout their pregnancy.

(D) The Contractor shall have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers shall be consistent with standards of practice and linked to the Contractor's care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care providers shall be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy.

(E) The Contractor's healthy pregnancy programs shall also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The Contractor shall refer to and coordinate care with the prenatal care providers concerning the treatment plan and risk factors. The Contractor's risk assessments shall be overseen by the Contractor's Medical Director.

(F) Assessment tools used by prenatal care providers and the Contractor shall include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the Contractor and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care.

(G) The Department recommends *Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists* as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The Department recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk shall receive care coordination/case management services.

(H) The Department recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on:

(1) evidence of clinical hepatitis during pregnancy;

(2) injection drug use;

(3) occurrence during pregnancy or a history of STDs; or

(4) judgment of the health care provider.

(I) When a woman is found to be HBsAg-positive, the Contractor shall provide HBIG and HB vaccine at birth. Initial treatments shall be given during the first 12 hours of life. The Contractor shall comply with all other requirements as specified in Utah Administrative Code R386-702-9.

(J) The Department recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Health Code 26-6-20. Testing for STDs shall be repeated in the 3rd trimester for Enrollees at high risk for exposure.

(K) The Department also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The Contractor shall encourage providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to:

(1) universal testing with an opt-out approach (testing of all pregnant women and not just those who appear to be at high risk for HIV;

(2) flexibility in the consent process; and

(3) prevention and referral through education during prenatal care.

(L) Prenatal care providers shall have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy shall be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive shall receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns.

(M) Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

(1) perinatal care coordination (T1017)

(2) prenatal and postnatal home visits

(3) group prenatal and postnatal education

(4) nutritional assessment and counseling

(5) prenatal and postnatal psychosocial counseling

(N) Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness shall be referred to an appropriate mental health care provider.

1.3.26 Services for Children With Special Needs

(A) In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care shall be provided in a timely manner. The specialized care shall comprehensively address all areas of need to be most effective and shall be coordinated with primary care and other services to be most efficient. The children's families shall be involved in the planning and delivery of the care for it to be acceptable and successful.

(B) All children with special health care needs shall have timely access to the following services:

(1) Comprehensive evaluation for the condition.

(2) Pediatric subspecialty consultation and care appropriate to the condition.

(3) Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

(4) Durable medical equipment appropriate for the condition.

(5) Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

(C) In addition, children with the conditions marked by * below shall have timely access to

coordinated multispecialty clinics, when Medically Necessary, for their disorder.

(D) The definition of children with special health needs includes, but is not limited to, the following conditions:

(1) Nervous System Defects such as:
Spina Bifida*
Sacral Agenesis*
Hydrocephalus

(2) Craniofacial Defects such as:
Cleft Lip and Palate*
Treacher - Collins Syndrome

(3) Complex Skeletal Defects such as:
Arthrogryposis*
Osteogenesis Imperfecta*
Phocomelia*

(4) Inborn Metabolic Disorders such as:
Phenylketonuria*
Galactosemia*

(5) Neuromotor Disabilities such as:
Cerebral palsy*
Muscular Dystrophy*
Complex Seizure Disorders

(6) Congenital Heart Defects

(7) Genetic Disorders such as:
Chromosome Disorders
Genetic Disorders

(8) Chronic Illnesses such as:
Cystic Fibrosis
Hemophilia
Rheumatoid Arthritis
Bronchopulmonary Dysplasia
Cancer
Diabetes
Nephritis
Immune Disorders

(9) Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

(E) The Contractor agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The Contractor further agrees to cooperate with the Department‘s quality assurance monitoring for this population by providing requested information.

1.3.27 Medical and Surgical Services of a Dentist

(A) Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

(B) Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

(C) The Contractor is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider shall refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the Contractor is responsible for coverage of the inpatient hospital stay.

(D) The Contractor is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

(E) The Contractor is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

(F) The Contractor is responsible for anesthesia associated with a Covered Service.

1.3.28 Diabetes Education

(A) The Contractor shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

(1) has recently been diagnosed with diabetes;

(2) is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee’s self-management plan; or

(3) is determined by the health care professional to require re-education or refresher training.

1.3.29 HIV Prevention

(A) The Contractor shall have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) shall be culturally and linguistically appropriate. All Enrollees shall be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

(B) Special attention shall be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

1.3.30 Pharmacy

(A) The Contractor shall cover all prescribed drugs as outlined in Attachment B that the Medicaid State Plan covers with the exception of the classes of drugs specifically listed in this Contract as being "carved out."

1.3.31 Dental Fluoride Varnish

(A) Application of dental fluoride varnish for children birth through 4 years as part of a well-child (CHEC) exam is a covered service.

1.3.32 Autism Services

Autism Services are Covered Services only to the extent as outlined in the Utah Autism Services Provider Manual.

Article 2 Summary of Co-Payment and Co-Insurance Requirements

2.1 Special Co-Payment Provisions

2.1.1 Co-Payments, Generally

(A) The Contractor shall ensure that co-pays required of Enrollees are consistent with the State Plan and the Department's co-pay rules and policies.

(B) The Contractor shall not charge co-pays to Enrollees who have been determined by the Department to have met his or her out of pocket monthly maximum. Enrollees may request that their co-payments be reviewed by the Department to determine whether or not the Enrollee has met his or her out of pocket monthly maximum amount. The Contractor shall refer any Enrollee seeking such a determination to the Department's Health Program Representatives.

2.1.2 Family Planning Co-Payments

Services and prescription drugs related to family planning are excluded from all co-payment and

co-insurance requirements.

2.1.3 Exemptions from Co-Payments

(A) The following are exempt from all co-payment and co-insurance requirements:

(1) Pregnant women and children under age 18

(2) Individuals whose total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families standard payment allowance

(3) Individuals receiving Hospice Services

(B) Information for the exemptions in 2.1.3 (A) (1) and (2) are transmitted in the eligibility transmission from the Department.

2.1.4 Special Rule for American Indian Co-Payments

The Contractor shall comply with the co-payment and co-insurance requirements for American Indians as stated in Section 5006 of the American Recovery and Reinvestment Act of 2009.

2.1.5 Special Rules for Pharmacy Co-Payments

Each Enrollee must pay a co-payment of $4.00 per prescription. The maximum co-payment to be charged by the ACO is $12.00 per Enrollee per month.

Attachment D – Covered Services
Non-Traditional Medicaid

Article 1 Covered Services, Limitations, & Exclusions

1.1 Special Provisions

1.1.1 Medicaid Provider Manuals

The Contractor shall administer Covered Services in accordance with the Medicaid Provider Manuals. Medicaid Provider Manuals provide detailed information regarding Covered Services and are available to the Contractor on the Department's website.

1.1.2 Non-Traditional Enrollees.

This Attachment D describes Covered Services, limitations and exclusions for Non-Traditional Medicaid Enrollees.

1.2 Covered and Carved Out Services

1.2.1 Covered and Carved Out Services, Generally

(A) The Contractor shall cover all services and codes for Non-Traditional Enrollees that Medicaid covers under the Medicaid State Plan and the 1115 waiver except when the service is

(1) specifically listed in this Contract as being "carved out" of this Contract;

(2) otherwise limited by this Contract; or

(3) limited by service limitations found in the State Plan or the 1115 Primary Care Network Demonstration waiver.

(B) The Parties agree that the Coverage and Reimbursement Code Look Up Tool and the Department's Provider Manuals are the official listings of the specific codes Medicaid covers pursuant to the Medicaid State Plan and the 1115 Primary Care Network Demonstration waiver. In the event of a conflict between the Coverage and Reimbursement Code Look Up Tool and the Department's Provider Manuals the Department retains the right to determine whether the codes are covered pursuant to the State Plan and the 1115 Primary Care Demonstration waiver.

(C) The Department shall have the right to interpret the State Plan and the 1115 Primary Care Demonstration waiver, Provider Manuals, Medicaid Information Bulletins and the Coverage and Reimbursement Code Look Up Tool.

(D) The Contractor is responsible for payment of Emergency Services 24 hours a day, 7 days a week whether the services were provided by a Participating Provider or a Non-Participating

Provider and whether the service was provided inside or outside of the Contractor's Service Area.

(E) Medicaid services can only be limited through utilization criteria based on Medical Necessity.

1.2.2 Categories of Carved out Services

(A) The Contractor is not responsible to cover the following Medicaid State Plan or Waiver services. These services are "carved out" of this Contract:

(1) In general, dental services including orthodontics and anesthesia for dental services are carved out except as provided in Section 1.3.25.

(2) Targeted case management: Specific codes: T1017, T1023

(3) Ambulance transportation services

(4) Care in a Nursing facility, Intermediate Care Facility, or a Long Term Acute Care hospital when the prognosis indicates that a stay longer than 30 Days will be required (see Attachment B, Section 4.5)

(5) Waiver Services:

(i) Home and Community – Based Waiver Services For Individuals 65 or Older

(ii) Home and Community – Based Waiver Services For Individuals With Acquired Brain Injury Age 18 and Older

(iii) Community Supports Waiver Services For Individuals with Intellectual Disabilities or Other Related Conditions

(iv) Home and Community – Based Waiver Services For Individuals with Physical Disabilities

(v) Home and Community – Based Waiver Services - New Choices Waiver

(vi) Home and Community – Based Waiver Services For Technology Dependent, Medically Fragile Individuals

(vii) Autism Waiver Services

(6) Specialized mental health services. Treatment for mental health conditions is a covered service when done by a Primary Care Provider. Mental health conditions may be handled by the Contractor's Primary Care Providers or referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. (See

Attachment B, Section 4.10)

(7) Substance use disorder services are carved out except for the service(s) specified in Section 1.3.19.

(8) Specific classes of drugs: Transplant Immunosuppressive Drugs, Attention Deficit Hyperactivity Disorder Stimulant Drugs, Anti-psychotic Drugs, Anti-depressant Drugs, Anti-anxiety Drugs, Anti-convulsant Drugs, Hemophilia Drugs, and the following Substance Use Disorder Treatment Drugs and their associated generics (if any) indicated for the same uses:

(a) Vivitrol®
(b) Revia®
(c) Suboxone®
(d) Campral®
(e) Antabuse®

(9) Services provided under the hemophilia waiver (disease management waiver). Hemophilia drugs given as part of an inpatient facility stay are not carved out.

(10) Methadone maintenance treatment services

(11) Transportation

(12) Psychological evaluations and testing

(13) Any services performed at an Indian Health Services (IHS), tribal facility or an Urban Indian Facility (UIF)

(14) Early intervention services

(15) School-based skills development program services

(16) Chiropractic services

(17) Services performed at the state hospital

(18) Services performed at the state developmental center

(19) Mental Health evaluations and psychological testing performed for physical health purposes including testing and evaluations prior to medical procedures, or for the purpose of diagnosing intellectual disabilities, developmental disorders, or related conditions. This does not include services described in Article 4.7.1 of Attachment B of this Contract.

1.2.3 Special Rules for Oxygen Concentrators

The Contractor is responsible for payment of oxygen concentrators for Enrollees living in counties with mandatory enrollment in ACO health plans as specified in the service area section of Article 2 in Attachment B.

1.2.4 Special Rules for Enrollees dually eligible for Medicare Part The Contractor is not required to cover benzodiazepines or barbiturates for any indications for Enrollees who are dually eligible for Medicare Part D.

1.3 Categories of Covered Services

1.3.1 Covered Services, General Requirements

This Attachment C lists broad categories of Covered Services.

1.3.2 Inpatient Hospital Services

Services furnished in a licensed, certified hospital are Covered Services.

1.3.3 Outpatient Hospital Services

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital are Covered Services.

1.3.4 Emergency Department Services

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

1.3.5 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are Covered Services.

1.3.6 General Preventative Services

Preventative services such as mammograms, Pap smears, and prostate exams are Covered Services.

1.3.7 Vision Care

(A) Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice are Covered Services.

(B) Covered Vision Services include, but are not limited to, the following:

(1) Eye examinations and care to identify and treat medical problems

(2) Eye refractions, examinations

(3) One eye examination every 12 months.

(C) Eyeglasses including frames, lenses and contacts are not Covered Services for Non-Traditional Enrollees generally, but are covered for CHEC enrollees.

1.3.8 Laboratory and Radiology Services

(A) Professional and technical laboratory and X-ray services furnished by licensed and certified providers are Covered Services.

(B) All laboratory testing sites, including physician office labs, providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

(C) Those laboratories with certificates of waiver shall provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

1.3.9 Physical Therapy

(A) Treatment and services provided by a licensed physical therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Limited to a combination of 10 visits per calendar year for Physical Therapy and Occupational Therapy.

1.3.10 Occupational Therapy

(A) Treatment and services provided by a licensed occupational therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified

occupational therapist.

(C) Necessary supplies and equipment shall be reviewed for medical necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Occupational Therapy services provided in the home are available only to Enrollees who are pregnant women or CHEC Enrollees.

(E) Limited to a combination of 10 visits per calendar year for Physical Therapy and Occupational Therapy.

1.3.11 Speech and Hearing Services

(A) Speech therapy services are not covered benefits for Non-Traditional Medicaid in general but are covered benefits for CHEC Enrollees.

(B) Audiology services and hearing aids, generally, are not covered benefits for Non-Traditional Medicaid but are covered benefits for CHEC Enrollees.

(C) Speech augmentative communication devices (SACDs) are a Covered Service for CHEC Eligible Enrollees. SACDs are a Covered Service for Enrollees who are not eligible for CHEC if the SACD(s) is Medically Necessary.

(D) Hearing evaluations or assessments for hearing aids are covered. Hearing aids covered only if hearing loss is congenital.

1.3.12 Podiatry Services

Services provided by a licensed podiatrist are Covered Services.

1.3.13 End Stage Renal Disease—Dialysis

Treatment of end stage renal dialysis for kidney failure is a Covered Service. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.3.14 Home Health Services

(A) Home health services are defined as part-time intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound are Covered Services. Home Health Services are based on a physician’s order and plan of care.

(B) Home health care shall be rendered by a Medicare-certified Home Health Agency.

(C) The Contractor agrees to comply with all federal regulations regarding surety bonds. The Contractor agrees to contract with only Medicare-certified Home Health Agencies who carry a

surety bond if federal regulations regarding this requirement are reinstated. The Department agrees to notify the Contractor if such federal regulations are reinstated.

(D) Personal care services as defined in the DEPARTMENT's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

(E) Speech and language services provided through home health providers are not covered services for Non-Traditional Enrollees.

1.3.15 Hospice Services

(A) Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are Covered Services. CHEC enrollees may elect to receive both palliative and aggressive care.

(B) Hospice care shall be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR or freestanding hospice facility, the Contractor is responsible for up to 30 days of hospice care.

1.3.16 Private Duty Nursing

Private Duty Nursing is not a covered service for Non-Traditional Medicaid Enrollees.

1.3.17 Medical Supplies and Medical Equipment

Medical Supplies and Medical Equipment are covered to the same extent for Non-Traditional Medicaid Enrollees as for Enrollees on Traditional Medicaid except for the exclusions listed for Durable Medical Equipment in the Non-Traditional Medicaid provider manual and the Coverage and Reimbursement Lookup Tool at: health.utah.gov/Medicaid.

1.3.18 Abortions and Sterilizations

(A) Abortions are covered only under the following conditions specified in the Federal Hyde Amendment:

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(B) Sterilizations are Covered Services to the extent permitted by Federal and State law.

(C) Both abortions and sterilizations shall meet the documentation requirement of 42 CFR 441,

Subparts E and F. These requirements shall be met regardless of whether Medicaid is primary or secondary payer.

1.3.19 Treatment for Substance Use

Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

1.3.20 Organ Transplants

(A) The following transplantations are Covered Services for all Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, and lung unless amended under the provisions of Attachment B, Article 4.9. Medical costs for the donor are only covered if the donor is Medicaid eligible.

1.3.21 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, freestanding ambulatory surgical centers and birthing centers.

1.3.22 Skilled Nursing Facility, Intermediate Care Facility and Long Term Acute Care Stays 30 Days or Less

(A) The Contractor shall provide as a Covered Service care for Enrollees in skilled nursing facilities, Intermediate Care Facilities and Long Term Acute Care (LTAC) hospitals requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less and the care in the facility is a cost effective alternative.

(B) When the prognosis of an Enrollee indicates that the stay shall be more than 30 days, the Contractor shall notify the Department and the facility of the prognosis determination and shall initiate disenrollment.

(C) Skilled nursing care is to be rendered in a facility which meets federal regulations of participation.

1.3.23 Services to CHEC Enrollees

(A) The Contractor shall provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

(B) The Contractor is not responsible for providing home and community-based services available through Utah's Home and Community-Based waiver programs.

(C) The Contractor shall cover the full early and periodic screening, diagnosis, and treatment services to all eligible CHEC Enrollees in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual.

(D) The Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules, including policies for Participating Providers to screen all members between six months and 72 months for blood lead levels. These policies and procedures shall emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC Enrollees.

(E) Non-Traditional Medicaid: There is no co-pay specific to services for CHEC Enrollees. Any co-pays for services to CHEC Enrollees are based on the type of service and the place of service.

(F) The only Non-Traditional Enrollees that qualify as CHEC Enrollees are individuals 18 years of age. Non-Traditional Enrollees ages 19 and 20 are specifically excluded from the CHEC program under the 1115 Primary Care Network Demonstration waiver.

1.3.24 Family Planning Services

(A) Family Planning Services are covered Services. Family Planning Services includes disseminating information, counseling, and treatments relating to family planning services.

(B) Family Planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law.

(C) Birth control services include information and instructions related to the following:

(1) Birth control pills;

(2) Depo Provera;

(3) IUDs;

(4) Barrier methods including diaphragms, male and female condoms, and cervical caps;

(5) Vasectomy or tubal ligations;

(6) Nuvaring; and

(7) Office calls, examinations or counseling related to contraceptive devices.

(D) Non-Traditional Medicaid Family Planning covered services are the same as Traditional Medicaid Family Planning services except the following are not covered:

(1) Norplant;

(2) Infertility drugs;

(3) In-vitro fertilization;

(4) Genetic Counseling.

1.3.25 Medical and Surgical Services of a Dentist

(A) Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

(B) Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

(C) The Contractor is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider shall refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the Contractor is responsible for coverage of the inpatient hospital stay.

(D) The Contractor is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

(E) The Contractor is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

(F) The Contractor is responsible for anesthesia associated with a Covered Service.

1.3.26 Diabetes Education

(A) The Contractor shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

(1) has recently been diagnosed with diabetes;

(2) is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan; or

(3) is determined by the health care professional to require re-education or refresher training.

1.3.27 HIV Prevention

(A) The Contractor shall have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) shall be culturally and linguistically appropriate. All Enrollees shall be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

(B) Special attention shall be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

1.3.28 Pharmacy

The Contractor shall cover all prescribed drugs as outlined in Attachment B that the Medicaid State Plan covers with the exception of the classes of drugs specifically listed in this Contract as being "carved out."

Article 2 Summary of Co-Payment and Co-Insurance Requirements

2.1 Special Co-Payment Provisions

12.1.1 Co-Payments, Generally

(A) The Contractor shall ensure that co-pays required of Enrollees are consistent with the State Plan and the Department's co-pay rules and policies.

(B) The Contractor shall not charge co-pays to Enrollees who have been determined by the Department to have met his or her out of pocket monthly maximum. Enrollees may request that their co-payments be reviewed by the Department to determine whether or not the Enrollee has met his or her out of pocket monthly maximum amount. The Contractor shall refer any Enrollee seeking such a determination to the Department's Health Program Representatives.

2.1.2 Family Planning Co-Payments

Services and prescription drugs related to family planning are excluded from all co-payment and co-insurance requirements.

2.1.3 Exemptions from Co-Payments

(A) The following Non-Traditional Enrollees are exempt from all co-payment and co-insurance requirements:

(1) Individuals whose total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families standard payment allowance

(2) Individuals receiving Hospice Services

(B) Information for the exemptions in 2.1.3 (A) (1) is transmitted in the eligibility transmission from the Department.

2.1.4 Special Rule for American Indian Co-Payments

The Contractor shall comply with the co-payment and co-insurance requirements for American Indians as stated in Section 5006 of the American Recovery and Reinvestment Act of 2009.

2.1.5 Special Rules for Pharmacy Co-Payments

Each Enrollee must pay a co-payment of $4.00 per prescription. The maximum co-payment to be charged by the ACO is $12.00 per Enrollee per month.

Attachment E–Quality and Performance

1.1 Quality Assessment and Performance Improvement Program

1.1.1 Quality Assessment and Performance Improvement, Generally

(A) Pursuant to 42 CFR 438.330, the Contractor shall have an ongoing comprehensive Quality Assessment and Performance Improvement Program (QAPIP) for the services it furnishes to its Enrollees.

(B) The QAPIP shall include a policymaking body which oversees the QAPIP, a designated senior official responsible for administration of the program, an interdisciplinary quality assessment and performance improvement committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body, and other functional areas of the organization.

(C) The Contractor agrees that CMS, in consultation with States and other stakeholders, may specify performance measures and topics for Performance Improvement Projects (PIPs) that would be required for the Contractor to implement.

1.1.2 Basic Elements of QAPIPs

(A) At minimum, the Contractor shall establish and maintain a QAPIP that complies with the following requirements:

(1) Conduct Performance Improvement Projects (PIPs) in accordance with Article 1.1.4;

(2) Collect and submit performance measurement data in accordance with Article 1.1.5;

(3) Have in effect mechanisms to detect both underutilization and overutilization of services;

(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs; and

(5) Have in effect a process for evaluating the impact and effectiveness of its QAPIP.

1.1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Articles 1.1.1 and 1.1.2.

(B) The Contractor shall submit its written QAPIP plan to the Department by April 1st of each year.

1.1.4 Performance Improvement Projects

(A) The Contractor shall have ongoing Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas, including any PIPs required by CMS or the Department.

(B) Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and that include the following:

(1) Measurement of performance using objective quality indicators;

(2) Implementation of interventions to achieve improvement in the access to and quality of care;

(3) Evaluation of effectiveness of the interventions based on the quality indicators in Article 1.1.4(B)(1); and

(4) Planning and initiation of activities for increasing or sustaining improvement.

(C) Before implementing a new PIP, the Contractor shall submit the topic to the Department for approval using a format specified by the Department.

(D) The Contractor shall report the status and results of each project, including those required by CMS, to the Department as requested by the Department.

(E) The Contractor agrees that the Department may, at its discretion, set up a timeframe and deadline for the Contractor to complete a PIP.

1.1.5 Performance Measurement

(A) Annually, the Contractor shall:

(1) Measure and report to the Department its performance, using standard measures required by the Department and/or CMS;

(2) Submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or

(3) Perform a combination of the above activities.

(B) The Contractor shall compile and submit to the Office of Health Care Statistics (OHCS):

(1) Audited Healthcare Effectiveness Data and Information Set (HEDIS) for the preceding calendar year by July 1 of each year as set forth in Utah Administrative Code R428-13-1, *et seq*; and

(2) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data to OHCS as set forth in Utah Administrative Code R428-12-12-1 *et seq*.

(C) Data, calculations for HEDIS and CAHPS, and results of standard measures shall include both Traditional and Non-Traditional Enrollees.

1.2 Quality Tracking and Monitoring

1.2.1 Quality Measures

(A) In addition to reporting the HEDIS and CAHPS measures to OHCS as required above, the Contractor shall report separately to the Department the quality measures specified in Article 1.2.4 by August 1st of each year.

(B) The Contractor agrees that the Department may amend the quality measures found in Article 1.2.4. The Department, when possible, shall consult with the Contractor prior to changing the reportable quality measures and, when possible, shall negotiate with the Contractor the effective date of any new quality measures.

(C) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

1.2.2 Quality Measure Targets

(A) The Contractor shall establish a targeted rate for each year of a five-year period for each quality measure listed in Article 1.2.4. The Contractor agrees that the five-year period shall be established by the Department.

(1) The Contractor's baseline rate and the national average rate for each quality measure shall be based on performance in the calendar year prior to the five-year period.

(2) For each quality measure, the Contractor's targeted rates shall adhere to the following:

(i) If the Contractor's baseline rate is below the national average rate, the targeted rate for year-five shall be at or above the national average rate as specified in Article 1.2.2(A)(1);

(ii) If the Contractor's baseline rate is at or above the national average rate, the targeted rate for year-five shall be at or above the baseline rate as specified in Article 1.2.2(A)(1).

(3) The Contractor agrees that the Department shall approve the Contractor's targeted rates for each quality measure.

1.2.3 Quality Targeted Improvement Plan

(A) The Contractor shall develop and implement a written plan for each quality measure describing how it will achieve or maintain the targeted rates as specified in Article 1.2.2. The written plan shall be in the Department-specified form called the Quality Targeted Improvement Plan (QTIP).

(B) The Contractor shall submit its QTIP on a date specified by the Department. The Department shall give the Contractor 60 days advance notice of the due date.

(C) The Contractor shall revise its QTIP (including targeted rates and implementation plan) upon request by the Department.

(D) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

1.2.4 Quality Measure Table

Population	Measure	Condition
(A) Maternity Care		
(1)	Postpartum Care Rate (HEDIS-PPC/ NQF 1391)	Preventive Services
(2)	Cesarean Rate for Nulliparous Singleton Vertex (NQF 0471)	Acute Care
(3)	Low Birth Weight (NQF 1382)	Acute Care
(B) Newborn/ Infant Care		
(1)	Childhood Immunization Status – Combo 3 (HEDIS-CIS/ NQF 0038)	Preventive Services
(2)	Well-Child Visits in the First 15 Months of Life (HEDIS-W15/ NQF 1392)	Preventive Services
(C) Pediatric Care		
(1)	Immunizations for Adolescents (HEDIS-IMA/ NQF 1407)	Preventive Services
(2)	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (HEDIS-W34/ NQF 1516)	Preventive Services
(3)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Assessment (HEDIS-WCC/ NQF 0024)	Preventive Services
(4)	Appropriate Treatment for Children with Upper Respiratory Infection (HEDIS-URI/ NQF 0069)	Acute Care
(5)	Getting Needed Care (Child CAHPS) (even-numbered years)	Access
(6)	Getting Care Quickly (Child CAHPS) (even-numbered years)	Access
(7)	Customer Service (Child CAHPS) (even-numbered years)	Access
(8)	How Well Doctors Communicate (Child CAHPS) (even-numbered years)	Access
(9)	Satisfaction with Health Care (Child CAHPS) (even-numbered years)	Satisfaction
(10)	Satisfaction with Health Plan (Child CAHPS) (even-numbered years)	Satisfaction
(11)	Satisfaction with Personal Doctor (Child CAHPS) (even-numbered years)	Satisfaction

Population	Measure	Condition
(12)	Satisfaction with Specialist (Child CAHPS) (even-numbered years)	Satisfaction
(D) Adult Care		
(1)	Breast Cancer Screening (HEDIS-BCS/ NQF 0031)	Preventive Services
(2)	Cervical Cancer Screening (HEDIS-CCS/ NQF 0032)	Preventive Services
(3)	Use of Imaging for Low Back Pain (HEDIS-LBP/ NQF 0052)	Acute Care
(4)	Antidepressant Medication Management (HEDIS-AMM/ NQF 0105)	Acute Care
(5)	Comprehensive Diabetes Care: Hemoglobin A1c Testing (HEDIS-CDC/ NQF 0057)	Chronic Care
(6)	Comprehensive Diabetes Care: Eye Exam (HEDIS-CDC/ NQF 0055)	Chronic Care
(7)	Controlling High Blood Pressure (HEDIS-CBP/ NQF 0018)	Chronic Care
(8)	Getting Needed Care (Adult CAHPS) (odd-numbered years)	Access
(9)	Getting Care Quickly (Adult CAHPS) (odd-numbered years)	Access
(10)	Customer Service (Adult CAHPS) (odd-numbered years)	Access
(11)	How Well Doctors Communicate (Adult CAHPS) (odd-numbered years)	Access
(12)	Satisfaction with Health Care (Adult CAHPS) (odd-numbered years)	Satisfaction
(13)	Satisfaction with Health Plan (Adult CAHPS) (odd-numbered years)	Satisfaction
(14)	Satisfaction with Personal Doctor (Adult CAHPS) (odd-numbered years)	Satisfaction
(15)	Satisfaction with Specialist (Adult CAHPS) (odd-numbered years)	Satisfaction

1.2.5 Quality Measure Corrective Actions

In the event that the Contractor's quality measure performance is not at or above the national average as required by this Article, the Contractor may be subject to the corrective actions found in Article 14 of Attachment B.

1.3 External Quality Review

1.3.1 External Quality Review, Generally

(A) Pursuant to 42 CFR Part 438, Subpart E, the Department shall arrange for External Quality Reviews (EQRs) to assess Contractor's management of quality, timeliness, and access to Covered Services.

(B) The Contractor shall maintain, and make available to the External Quality Review Organization (EQRO), all clinical and administrative records for use in EQRs.

(C) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

1.3.2 Contractor Staffing Requirements

(A) The Contractor shall designate an individual to serve as a liaison for the EQRs.

(B) The Contractor shall designate representatives, as needed, including but not limited to a quality improvement representative and a data representative to assist with EQRs.

1.3.3 Copies and On-Site Access

(A) The Contractor shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during an on-site review.

(B) Document copying costs are the responsibility of the Contractor.

(C) Enrollee information includes, but is not limited to, medical records, administrative data, encounter data, and claims data, maintained by the Contractor or its Participating Providers.

(D) On-Site EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate work space, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Contractor shall assign appropriate staff to assist during on-site EQRs.

(G) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

1.3.4 Timeframe for Providing Information

(A) The Contractor shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by the Department.

(B) The Contractor agrees that the Department shall review requests for extensions of these timeframes and that the Department shall approve or disapprove the request.

1.4 Miscellaneous Quality Provisions

1.4.1 Accrediting

(A) The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.

(B) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide the Department a copy of its most recent accreditation review including;

(1) Accreditation status, survey type, and level (as applicable);

(2) Accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings, and

(3) Expiration of the date of accreditation.

Attachment F - Payment Methodology

Article 1 Risk Based Contract

1.1 Contract Classification

(A) This Contract is classified as a Risk Contract.

(B) The Department shall provide all services required by this Contract and the Capitation Payments and any supplemental payments made by the Department shall be considered payment in full for all services covered under this Contract.

(C) The Contractor incurs loss if the cost of furnishing the services exceeds the payments under the Contract.

(D) The Contractor may retain all payments under this Contract.

(E) Pursuant to 42 CFR 438.6(e) the Contractor may provide services to Enrollees that are in addition to those covered under the State Plan although, the cost of these services cannot be included when determining rates.

(F) The Parties understand and agree that Capitation Rates may only be made by the Department and retained by the Contractor for Medicaid-Eligible Enrollees.

(G) The Contractor shall report to the state within 60 calendar days when it has identified a capitation payment or other payments in excess of the amounts specified in this Contract.

Article 2 Payments

2.1 Payment Schedule

(A) The Department shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the Department's 820 Enrollment Report whether or not the Enrollee receives a Covered Service during that month.

(B) The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, the Department reserves the right to amend the rates to reflect the change in funding. The Department shall notify the Contractor of any change in the Capitation Rates due to a loss of funding. When possible, the Department shall make reasonable efforts to notify the Contractor at least 30 days prior to the change in rates. In the event of a change in Capitation Rates pursuant to a loss of funding, if the Contractor determines that the new rates are unacceptable, the Contractor may terminate this Contract after it provides 30 days written notice of intent to terminate to the Department.

2.2 Capitation Rates

The Parties understand and agree that the Capitation Rates payable by the Department to the Contractor are subject to approval by CMS. The Contractor shall continue to pay the Contractor the CY 2017 Capitation Rates which were approved by CMS for Traditional Enrollees and Non-Traditional Enrollees until CMS approves the CY 2018 rates. Upon receiving notification of Capitation Rate approval from CMS, the Department shall recoup previously paid Capitation Payments and replace them with the approved Capitation Rate for the applicable time period. The Department will notify the Contractor upon receiving CMS approval of the rates and the Parties shall execute an amendment to this Contract to include rates approved by CMS.

2.3 Delivery Case Rate

(A) The Department shall reimburse the Contractor a Delivery Case Rate per delivery when the delivery occurs at 22 weeks or later, regardless of viability. The Delivery Case Rate is intended to include all Medically Necessary inpatient and physician expenditures associated with the delivery. The Delivery Case Rate does not include expenses associated with prenatal care. The Delivery Case Rate is in addition to the monthly Capitation Rate for the Enrollee.

(B) The Parties understand and agree that the Delivery Case Rates payable by the Department to the Contractor are subject to approval by CMS. The Department shall continue to pay the Contractor the Delivery Case Rate which were approved by CMS for CY 2017 until CMS approves the CY 2018 rates. Upon receiving notification of Capitation Rate approval from CMS, the Department shall recoup previously paid Capitation Payments and replace them with the approved Capitation Rate for the applicable time period. The Department will notify the Contractor upon receiving CMS approval of the rates and the Parties shall execute an amendment to this Contract to include rates approved by CMS.

2.4 Payment Procedures

(A) The Department shall make payments to the Contractor through its Medicaid Management Information System (MMIS) for all Enrollees under this Contract.

(B) Unless a sanction provision found in Attachment B applies, the Department shall pay the contractor the Capitation Rates designated in Section 2.2 of this Attachment F for all current Enrollees listed in the Department's 820 Enrollment report.

(C) On a weekly basis, the Department shall provide the Contractor with the following reports:

(1) an 820 Enrollment Report that includes identifying information on all Enrollees for which the Department has paid a Capitation Rate; and

(2) an 820 Enrollment Summary report that contains summary aggregate information of the count of Enrollees by month and Capitation Rate Cell.

2.5 Payment Adjustments

(A) If the Contractor believes an error in capitation payment has been made by the Department, the Contractor shall notify the Department, in writing. The Contractor shall supply supporting documentation for the Department's review. If appropriate, the Department shall adjust the Contractor's payment.

(B) The Department shall automatically adjust Capitation Rates when an Enrollee's aid category is changed retroactively. This information will be transmitted to the Contractor via the Eligibility Transmission.