UTAH DEPARTMENT OF HEALTH CONTRACT AMENDMENT

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

1603902	162700723
Department Log Number	State Contract Number

1. CONTRACT NAME: The name of this contract is CHIP -- Select Health Amendment 1.

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

3. PURPOSE OF CONTRACT AMENDMENT: To extend the contract for an additional year, through June 30, 2018.

4. CHANGES TO CONTRACT:

    1. To extend the contract for an additional year, through June 30, 2018.
    2. In order to prevent duplication of the contract termination dates, Attachment B has been modified to remove those dates. The effective dates of the contract are still referenced on page one of the contract. The original Attachment B from the initial contract effective 10/1/2015 will be replaced with the attached modified version effective 3/1/2017.

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective [03/01/2017]

6. 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.

7. 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.

Contract with Utah Department of Health and SELECTHEALTH, **Log #** 1603902

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By [redacted] 3/22/17
Patricia R Richards Date
President and CEO

STATE

By: [redacted] 4/6/2017
Shari A. Watkins, C.P.A. Date
Director, Office Fiscal Operations

Article 1 Introductory Provisions

1.1 Parties

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

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:

SelectHealth, Inc.
5381 Green Street
Murray, UT 84123

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

The Service Area is the specific geographic area within which the Enrollee must reside to enroll in the Contractor's Health Plan. The Service Area for this Contract is the entire state of Utah.

Article 2 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 CHIP 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 CHIP program.

Action means:

1. the denial or limited authorization of a requested service, including the type or level of 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 and the denial could result in the Enrollee liable for payment;
4. the failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times; or
5. the failure of the Contractor to act within the time frames established for resolution and notification of Grievances and Appeals.

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.

Appeal means a request for review of an Action taken by the Contractor.

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

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.

Capitation Payment means the payment the Department makes to the Contractor on behalf of each Enrollee for the provision of Covered Services. 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 CHIP eligibility group or Capitation Rate cell.

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, Participating Providers, agents, or subcontractors with a potential enrollee for the purposes of marketing.

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/CHIP identification numbers, medical claims and Encounter Data.

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

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

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

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

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

Encounter Data means the compilation of data elements, as specified in the Department's 837 companion guide, identifying an Encounter.

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

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 1.4 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 or CHIP program will not be reimbursed under Medicaid or CHIP.

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.

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 or CHIP 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 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. Under Utah Code Ann. §63J-41-102(5), Fraud means intentional or knowing: (a) deception, misrepresentation, or up coding in relation to Medicaid or CHIP funds, costs, a claim, reimbursement, or services; or (b) a violation of a provision of Utah Code Ann.§§ 26-20-3 through 26-20-7.

Grievance means an expression of dissatisfaction about any matter other than an Action.

Grievance and Appeals System means an overall system that includes a Grievance process, an Appeal process, and access to the State's fair hearing system.

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 federally defined Prepaid Ambulatory Health Plan, a federally defined Primary Care Case Management system, or a federally defined Managed Care Organization

under contract with the Department to provide specified physical health care services to a specific group of CHIP Eligible Individuals.

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.

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

Managed Care Organization 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 to also meet the following conditions: (i) Makes the services it provides to its Medicaid or CHIP Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid or CHIP recipients within the area served by the entity.

CHIP Eligible Individual means any individual who has been certified by the Utah Department of Human Services or the Utah Department of Workforce Services to be eligible for CHIP benefits.

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, Participating Providers, agents or subcontractors to a potential enrollee that can reasonably be interpreted to influence the potential enrollee to enroll in Contractor's CHIP product, or either to not enroll in, or to disenroll from an another Health Plan's CHIP 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 Fraud Control Unit (MFCU) means the statutorily authorized criminal investigation unit charged with investigating and prosecuting the Medicaid and CHIP fraud in the Utah Attorney General's Office.

Medically Necessary or Medical Necessity means any medical service that is (1) reasonably

calculated to prevent, diagnose, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause deformity or malfunction, or threaten to cause a handicap; and (2) there is no equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly. To be considered Medically Necessary, the medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality.

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.

Non-Participating 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 subcontract or any other pre-arranged payment agreement with the Contractor.

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

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

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

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

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

2. Any Medicare intermediary or carrier: and

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

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.

Participating Provider means 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 has a contractual agreement with the Contractor to provide health care services to Enrollees.

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 CHIP 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.

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, or 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 Enrollees.

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 Participating Provider or a Non-Participating Provider.

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

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

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 and CHIP 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 and does not include agreements with Participating Providers.

Subcontractor means (1) an individual, agency, or organization to which the Contractor has contracted or delegated some of its management functions or responsibilities.

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 or CHIP.

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.

Four Day Grace Period means the four day grace period granted to eligible applicants as currently defined in the Utah Department of Health CHIP Policy Manual Section 602-1.

Timely Post-Delivery Follow-Up Care means health care that is provided (1) following the discharge of a mother and her newborn from the inpatient setting; and (2) in a manner that meets the health needs of the mother and her newborn, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24 to 72 hour period immediately following discharge.

Non-Covered Service or **Non-Covered Item** means a medical service or item that is not a benefit to the Enrollee pursuant to this Contract, or is a medical service or item that does not meet Medical Necessity criteria for amount, duration, as described in the Utah State Plan.

CHIP means the Children's Health Insurance Program authorized by Title XXI of the Social Security Act.

Article 3 Enrollment Services

3.1 Marketing Activities

(A) The Contractor, its employees, Participating Providers, agents or subcontractors shall not conduct direct or indirect Marketing of the Contractor's 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.

3.1.1 Prohibited Marketing Activities

(A) Contractor, its employees, Participating 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 Outreach Activities

3.2.1 Outreach Activities, General Rules

(A) The Contractor may conduct outreach activities and produce outreach materials that promote the CHIP program, generally. The Contractor is not allowed to conduct outreach activities and/or produce marketing materials which promotes its individual CHIP Health Plan.

(B) Any outreach materials must be submitted to the Department for Department approval prior to use or distribution. This includes new outreach materials as well as changes being made to existing outreach materials. The Contractor shall submit outreach materials to the Department public information officer and to the CHIP Director either by email or in a format approved by the Department. The Department shall provide its approval or disapproval of the outreach materials in writing. If the Department does not provide approval or disapproval of the materials within 15 days of the request, and if the Department does not request additional information or correction to the material, the Contractor may deem the materials approved by the Department.

(C) The Contractor shall notify the Department of all events within the State of Utah that are events that the Contractor intends to organize or participate in which the Contractor intends to conduct outreach activities. The Contractor shall notify the Department of such events at least five days in advance of the event or activity. The Department shall provide its approval or disapproval of the event in writing. Representatives from the Contractor's Health Plan may not promote the Contractor's Health Plan by wearing clothing with company logos or handing out items to Potential CHIP enrollees that specifically promotes the Contractor's Health Plan.

(D) In the event that the Contractor violates any of the provisions found in this Article the Contractor shall be subject to the sanctions found in Article 15.

3.3 Enrollment Process

3.3.1 Enrollee Choice

(A) The Department or the Department's designee shall determine a Potential Enrollee's eligibility for Enrollment and will offer Potential Enrollees a choice among all available Health Plans. If the Enrollee does not select a Health Plan, then the Department will assign the Enrollee to a Health Plan.

(B) The Department shall certify and the Contractor agrees to accept the individuals who are eligible to be enrolled in the CHIP program. The Contractor shall enroll individuals in the order in which they apply.

(C) Each Enrollee can be enrolled or disenrolled in a Health Plan independent of the enrollment or disenrollment of any other children in the family.

(D) On an annual basis, Enrollees shall be permitted to transfer from one Health Plan to another without cause during the Department-defined open enrollment period.

(E) The Department may, at any time, revise its 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 shall be bound by the changes in enrollment procedures.

3.3.2 Prohibition Against Conditions on Enrollment

(A) Contractor must accept eligible Enrollees 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, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

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

3.3.3 Period of Enrollment

(A) An Enrollee shall be considered enrolled in the Contractor's Health Plan beginning on the effective date show on the Eligibility Transmission.

(B) An Enrollee shall be enrolled in the Contractor's Health Plan until the earliest of the following:

(1) the end of the Contract;

(2) the end of the period of CHIP eligibility;

(3) the date the Enrollee has changed Health Plans; or

(4) the date the Enrollee is disenrolled.

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

(D) Generally, the enrollment period is for one year from the time of enrollment.

3.3.4 CHIP and Medicaid Eligibility

(A) If a CHIP Enrollee becomes eligible for Medicaid, CHIP coverage will end the last day of the month prior to the start of Medicaid eligibility.

(B) The Contractor will make a good faith effort to recover claims paid to a Provider after the date coverage began with Medicaid. The Contractor will recover such claims according to industry standards. The Contractor will use recovered claims to offset the total claims expenses.

3.3.5 CHIP and Other Health Insurance

(A) If a CHIP Enrollee becomes eligible for private insurance during the same month or a month previously covered by CHIP, CHIP coverage will end the last day of the month in which 10 day proper notice of closure can be given.

(B) The Contractor shall coordinate with the private insurance company to recover claims paid after the date coverage began with the private insurance. If the Contractor chooses to coordinate with the private insurance company, the Contractor shall pay as a secondary insurance. The Contractor may not recover claims from the provider other than when coordinating with the private insurance company and paying as a secondary insurance plan. The Contractor will use recovered claims to offset the total claims expenses. The Contractor shall not bill the CHIP Enrollee.

3.3.6 CHIP and Other Pharmacy Coverage

If the Contractor paid a pharmacy claim during any month in which the CHIP Enrollee became Medicaid eligible or in a month in which the Managed Care Plan has changed, the Contractor shall report payment of the pharmacy claims to the Department. The Department shall reinstate the premiums for the month in question. The Contractor shall not bill the CHIP Enrollee.

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 CHIP 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 American Indians) eligibility start date, third party liability coverage, county, address, and phone number.

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

(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 Contractor's Health Plan and qualifies for CHIP Assistance under Title XXI 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 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.

3.4.3 Enrollees in an Inpatient Hospital Setting

If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a terminated Enrollee on the Contractor's Eligibility Transmission or he or she is otherwise disenrolled, the Contractor shall remain financially responsible for the Enrollee's care until the Enrollee is discharged.

3.5 Member Orientation

3.5.1 Initial Contact, General Orientation

(A) The Contractor's representative shall ensure that each Enrollee's family or guardian receives the Contractor's Member Handbook within 21 calendar days after the Contractor has been notified of the Enrollee's Enrollment in the Contractor's Health Plan. The Contractor shall maintain written or electronic records of such initial contact.

(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 Enrolment in the Contractor's Health Plan. The Contractor shall maintain written or electronic records of such initial contact.

(1) If the Contractor 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, 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) The availability and accessibility of all Covered Services;

(3) The rights and responsibilities of the Enrollee under the Contractor's Health Plan, including the right to file a Grievance or an Appeal and how to file a Grievance or an Appeal;

(4) The right to terminate enrollment with the Contractor's Health Plan;

(5) Encouragement to make a medical appointment with a Provider; and

(6) Encouragement to use well-child services and receive immunizations.

(E) The Contractor shall also provide the information described in Section 3.5.1(D) to the Enrollee upon request from the Enrollee.

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 representatives during the initial contact to identify Enrollees with Special Health Care Needs.

(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 designated individual with knowledge of coordination of care, case management services, and other services necessary for such Enrollees. The Contractor's designated individual, with knowledge of coordination of care for Enrollees with Special Health Care Needs, shall make a good faith effort to contact such Enrollee within ten working days after identification to begin coordination of health care needs, as necessary.

3.5.3 Identification Card

(A) The Contractor shall issue an identification card to all Enrollees. The identification card shall contain the following information:

(1) Children's Health Insurance Program (CHIP);

(2) Whether the Enrollee is, Plan B or Plan C, and if they are Native American.

(3) The name of Contractor's Health Plan;

(4) A toll free Member Service number.

(B) The Contractor shall issue the identification card to new Enrollees within 21 calendar days after the Department notifies the Contractor that the Enrollee has been enrolled in the Contractor's Health Plan.

(C) The Contractor must issue a new identification card to incumbent Enrollees when their coverage terminates for 60 days or more before reinstating with the Contractor's Health Plan, when the Enrollee changes Plans (B or C), or when the Enrollee has changes to their co-pay exempt status.

(D) The Contractor is not required to issue an identification card to Enrollees who have qualified for only retroactive enrollment in the Contractor's Health Plan.

3.6 Member Education

3.6.1 Enrollee information Requirements, Generally

The Contractor shall write all Enrollee and Potential Enrollee informational, instruction, and educational material, including the member handbook, in a manner that may be easily understood at the sixth grade reading level.

3.6.2 Prevalent Language and Alternative Formats

(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 available all written Enrollee informational and instructional materials, including the member handbook, in the prevalent non-English languages. Written materials include vital documents such as applications, consent forms, release of information forms, letters containing important information, etc.

(C) The Contractor shall make Enrollee informational and instructional materials, including the member handbook, available in alternative formats that take into consideration the special needs of those who are visually limited or have a limited reading proficiency. Such alternative formats might include audio or video recordings.

3.6.3 Member Handbook

(A) On a yearly basis, the Contractor shall submit its member handbook to the Department for review and approval prior to general distribution. During open enrollment, the Contractor shall submit its member handbook to the Department for review within the thirty days after the Department has notified the Contractor of benefit changes for the new plan year. The Department shall notify the Contractor in writing of its approval or disapproval within thirty working days after receiving the member handbook unless the Department and the 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) At minimum, the member handbook shall explain in clear terms the following information:

(1) The amount, duration, and scope of benefits provided by the Contractor described in sufficient detail to ensure that Enrollees understand the scope of service and the benefits to which they are entitled;

(2) The Contractor's procedures for obtaining Covered Services, including any service authorization requirements; how and under what circumstances out of area services are covered; policy on referrals to specialty care; and procedures for resolving Enrollee issues related to authorization of coverage or payment for services;

(3) The extent to which, and how, after-hours emergency coverage is provided including:

(i) what constitutes an Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services;

(ii) the fact that prior authorization is not required for Emergency Services;

(4) Information about immunizations and well-child visits;

(5) A description of Enrollee cost-sharing requirements;

(6) Toll free Member Services telephone number;

(7) A description of the Member Services function;

(8) Information on the availability of written materials in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency, and a statement on how to access these formats; and

(9) How the Enrollee may file a Complaint, Grievance, or Appeal.

(10) Names, locations, telephone numbers of, and non-English languages spoken by, current, Participating Providers in the Enrollee's service area, including identification of Participating Providers that are not accepting new patients. This includes, at a minimum, information on Primary Care Providers, specialists, and hospitals;

(11) Any restrictions on the Enrollee's freedom of choice among Participating Providers;

(12) The Post-Stabilization Care Services rules set forth at 42 CFR 422.113(c); and

(13) Information on Grievance, Appeal, and State fair hearing procedures and timeframes as provided in 42 CFR 438.400 through 42 CFR 438.424, in a Department approved description that shall include the following:

(i) the Enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;

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

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

(iv) the availability of assistance in the filing process;

(v) the Enrollee's ability to file a Grievance with the Contractor if the Enrollee has a complaint or concern with regard to a Provider;

(vi) the toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

(vii) the fact that, when requested by the Enrollee:

(a) disputed services will continue if the Enrollee files an Appeal or a request for a State fair hearing within the timeframes specified for filing, and

(b) The Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee.

(C) The Contractor shall notify the Department when it makes changes to the member handbook at least 90 days prior to the changes taking effect. If the Department deems the changes being made to the member handbook to be "significant" the Contractor shall give each enrollee written notice of the change at least 30 days prior to the intended effective date of the change. The Department agrees to notify the Contractor of information deemed to be "significant" at least 60 calendar days prior to the intended effective date.

3.6.4 Additional Information to Enrollees

(A) The Contractors shall annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to file an Appeal or Grievance.

(B) The Contractor shall make a good faith effort to give written notice of termination of a Participating 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 Participating Provider.

3.7 Disenrollment

3.7.1 Disenrollment Initiated by Enrollee, 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 CHIP eligibility for a period of two months or less and the temporary loss of CHIP eligibility caused the Enrollee to miss the annual disenrollment period.

3.7.2 Limited Disenrollment, With Cause

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

(1) The Enrollee moves out of the Contractor'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) the Contractor does not, because of moral or religious objections cover the service the Enrollee seeks;

(5) Enrollee becomes emancipated; or

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

3.7.3 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.

3.7.4 Disenrollment Initiated by Contractor

(A) The Contractor may not terminate an Enrollee's enrollment because of an adverse change in the Enrollee's health or because of the Enrollee's utilization of Covered Services.

(B) The Contractor may initiate disenrollment of any Enrollee for one or more of the following reasons:

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

(2) When the Enrollee ceases to be eligible for medical assistance under the State's Title XXI State Plan and as finally determined by the Department;

(3) Upon expiration of the Contractor's Contract with the Department;

(4) Confinement of an Enrollee in an institution when confinement is not a Covered Service under this contract;

(5) 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

(6) When the Contractor has determined that the Enrollee has other valid health insurance coverage.

(C) To initiate disenrollment of an Enrollee's participation in the Contractor's Health Plan, the Contractor shall provide the Department with documentation justifying the proposed disenrollment.

(1) The Department shall approve or deny the disenrollment request by email or in writing within thirty days of receipt of the request. Failure by the Department to deny a

disenrollment request within thirty days shall constitute an approval of the Contractor's disenrollment request.

(2) 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 right to file a Grievance or Appeal. The Contractor shall provide a copy of the written notice to the Department at the time the notice is sent to the Enrollee.

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

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 as promptly and continuously as is consistent with generally accepted standards of medical practice.

(B) 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.

(C) 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.

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 pay for all Covered Services listed in Attachment C. The Contractor shall also be responsible to pay for Covered Services that are, subsequent to the execution of this contract, deemed Covered Services due to amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines or policies or made pursuant to court or administrative orders.

(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 Participating Provider or a Non-Participating Provider and whether the service was provided inside or outside of the Contractor's Service Area.

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 CHIP Eligible Individual shall be considered incorporated by this Contract and the Contractor shall be required to provide those benefits to CHIP 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.

4.3 Covered Services, Emergency Services

4.3.1 Emergency Services, Generally

(A) The Contractor is responsible for coverage and payment of Emergency Services for treatment of Emergency Medical Conditions 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 Participating Provider or a Non-Participating Provider.

(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-Participating Provider without penalty.

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 Participating Provider or a Non-Participating 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, Mental Health and Maternity

4.5.1 Mental Health Services Coordination

(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 and referred to a mental health provider when more specialized services are required for the Enrollee.

4.5.2 Maternity Stays

(A) The Contractor is responsible for paying for and providing post-delivery care services to a mother who is an Enrollee and her newborn as follows:

(1) inpatient care for a minimum of 48 hours of inpatient care following a normal vaginal delivery;

(2) inpatient care for a minimum of 96 hours of inpatient care following a caesarean section; and

(3) the Contractor shall not require the Provider attending the mother and her newborn to obtain authorization from the Contractor in order to keep the mother and her newborn in the inpatient setting for the periods of time described in Article 4.5.3 (A)(1) or (2).

(B) The Contractor shall not be required to provide coverage for post-delivery inpatient care for a mother who is an Enrollee and her newborn during the periods described in Article 4.5.3(A)(1) or (2) if:

(1) the attending Provider, in consultation with the mother, discharges the mother and the newborn prior to the expiration of the time periods described in Article 4.5.3(A)(1) or (2); and

(2) the Contractor provides Timely Post-Delivery Follow-Up Care.

(C) Post-delivery care shall be provided to a mother and her newborn by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in a hospital.

4.6 Diabetes Education

4.6.1 Contractor Provision of Diabetes Education

(A) Under orders of a Provider with prescribing authority, 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; or

(2) is determined by the Provider 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 Provider to require re-education or refresher training.

4.7 Covered Services, Hospice

If a Potential Enrollee is receiving hospice services at the time of enrollment in the Contractor's Health Plan, or if an Enrollee is already enrolled in the Contractor's Health Plan and has less than six months to live, the Enrollee must be offered hospice services or the continuation of hospice services if he or she is already receiving such services.

4.8 Covered Services, Enrollees with Special Health Care Needs

4.8.1 Identification of Enrollees with Special Health Care 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.

4.8.2 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.

4.8.3 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-Participating 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 Participating Provider may make for an Enrollee or Child with Special Health Care Needs.

4.8.4 Collaboration for Enrollees with Special Health Care Needs

(A) 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.

Article 5 Delivery Network

5.1 Availability of Services

5.1.1 Network Requirements

(A) The Contractor shall maintain and monitor a network of appropriate, Participating Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract.

(B) The Contractor shall have at least two primary care providers within 40 miles of each Enrollee's residence. This requirement shall not apply to rural areas where there is a general shortage of Primary Care Providers.

(C) If the Department determines that the Contractor does not have a sufficient Participating Provider network, the Department shall give written notice to the Contractor of its non-compliance. Upon receipt of the notice, the Contractor shall have 90 days to become compliant. If the Contractor is non-compliant after 90 days, an Enrollee may use any Primary Care Provider whose practice address is within 40 miles of the Enrollee's residence and the Contractor shall reimburse that provider in accordance with the rates found in Attachment C.

5.2 Relationships with Subcontractors and Delegation of Duties

5.2.1 Generally

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

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

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

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

(E) The Contractor shall monitor the Subcontractor's performance on an on-going basis that shall be subject to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations.

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

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

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

5.2.2 Written Agreements, , Specific Requirements

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

(1) Adequate information about the Grievance, Appeal, and State fair hearing procedures and timelines so that the Provider can comply with the Grievance and Appeals Systems requirements including:

(i) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;

(ii) The Enrollee's right to file Grievances and Appeals;

(iii) The requirements and timeframes for filing a Grievance or Appeal;

(iv) The availability of assistance in the filling process;

(v) The toll-free numbers that the Enrollee can use to file a Grievance or Appeal by phone;

(vi) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or request a State fair hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and

(vii) Any State-determined Provider Appeal rights to challenge the failure of the Contractor to cover a service.

5.2.3 Other Provider-Subcontractor Requirements

(A) All of the Contractor's Subcontracts and agreements with Participating Providers will include a provision stating that if either party wishes to terminate the subcontract or agreement, whichever party initiates the termination must give the other party written notice of termination at least 30 calendar days prior to the effective termination date.

(B) The Contractor shall notify the Department of a Subcontractor or Participating Provider agreement being terminated either when the Contractor initiates termination or the Contractor receives notice of termination from the Subcontractor or Participating Provider.

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

(D) All of the Contractor's Participating Providers shall be aware of the Contractor's Quality Assurance Plan and activities. All of the Contractor's agreements with Participating Providers shall include a requirement securing cooperation with the Contractor's Quality Assurance Plan and activities and shall allow the Contractor access to the medical records of Enrollees being treated by Participating Providers.

(E) 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.

5.3 Contractor's Selection of Participating Providers

5.3.1 Participating Provider Selection, Generally

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

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

5.3.2 Excluded Providers

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

5.3.3 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.

5.3.4 Non-Inclusion of Providers

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

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

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

5.3.5 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.

5.3.6 Primary Children's Medical Center

The Contractor shall enter into a Participating Provider agreement with Primary Children's Medical Center.

5.3.7 Participating Provider Hospital Reporting Requirements

(A) The Contractor shall submit to the Department by May 1 of each year, a list of hospitals with which the Contractor has entered into a Participating Provider agreement. The Contractor shall state on this list any restrictions or limitations to clients receiving all Covered Services at any of the hospitals on the list.

(B) In the event that the Participating Provider agreement between the Contractor and one of the hospitals on the list described in Article 5.3.7(A) is terminated, the Contractor shall:

(1) notify the Department within two business days of the Contractor having knowledge that the Participating Provider agreement with a hospital will be terminated;

(2) notify CHIP Enrollees living within a 40 mile radius of the hospital within 10 calendar days of the termination effective date;

(3) guarantee access to all Covered Services to Enrollees living with a 40 mile radius of the terminated hospital through whichever of the following dates is later:

(i) the end of the month following the month the Contractor notified the Department;

(ii) the termination date of the Participating Provider agreement between the hospital and the Contractor; or

(iii) the date of discharge if the Enrollee was admitted prior to Article

5.3.7(B)(1)(i) or (ii); and

(4) in the event that there is no other hospital that is a Participating Provider within a 40 mile radius of the terminated hospital, allow Enrollees to obtain Covered Services at any hospital within a 40 mile radius without imposing any requirements for prior authorization or other restrictions that would be different from those applied to contracted hospitals.

(C) Termination of a hospital as a Participating Provider is considered a major change to the Contractor's network of Participating Providers. The Department will allow Enrollees an opportunity to transfer to another Health Plan.

5.4 Payment of Provider Claims

5.4.1 General Requirements

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

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

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

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

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

5.4.3 Coverage Start Dates

(A) The Contractor is responsible for making payment on claims for Enrollees from the earlier of:

(1) the first day of the month of Enrollee's application is submitted; or

(2) during the Four Day Grace period from the date of application.

5.4.4 Federally Qualified Health Center and Rural Health Clinic Payments

The Contractor shall pay to Federally Qualified ("FQHCs") and Rural Health Clinics ("RHCs") with which it is contracted an amount not less than what it pays other similar providers that are not FQHCs and RHCs.

5.4.5 Division of Community and Family Health Services Payments

(A) When an Enrollee qualifies for special services offered through the Utah Department of Health's Division of Community and Family Health Services ("DCFHS"), the Contractor agrees to reimburse DCFHS at the standard CHIP rate for one outpatient team evaluation and one follow-up visit when the Enrollee becomes Eligible and selects the Contractor's Health Plan.

(B) The Contractor shall waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit.

(C) The services provided in the outpatient team evaluation and follow-up visit for which the Contractor must reimburse DCFHS are limited to the Covered Services that the Contractor is otherwise obligated to provide under this Contract. The Contractor may subcontract with DCFHS.

5.4.6 Indian Health Services Contracts

(A) The Contractor shall make a good faith effort to subcontract with Indian Health Services. Any such subcontract shall be comparable to subcontracts offered to other Participating Providers.

(B) If an Indian health care Provider is a Participating Provider and a Primary Care Provider, the Contractor must allow Native American Enrollees to choose the Indian health care Provider as the Native American Enrollee's Primary Care Provider.

(C) The Contractor must demonstrate that it has sufficient Indian health care providers as Participating Providers to ensure that Enrollees have timely access to Covered Services.

(D) The Contractor agrees to make prompt payment to Indian Health Services in accordance with 42 CFR 447.45 and 42 CFR 447.46.

(E) The Contractor shall pay an Indian health care provider that is both an FQHC and a Non-Participating Provider at the same rate that the Contractor would pay a Participating Provider.

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 CHIP 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 Fraud, Waste, and Abuse plan to the Department, upon the Department's request and the compliance plan shall be subject to the Department's approval.

(C) 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.

(D) 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 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 Federal and State standards;

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

(3) Effective training and education for the compliance officer and the Contractor's employees;

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

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

(6) 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

(7) Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract.

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

(A) Pursuant to Utah Code Ann. §63J-4a-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") or 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.

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 CHIP (such as, the recipient misrepresented facts in order to become or maintain CHIP 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 CHIP 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.

6.2 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 CHIP 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 Participating 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 Participating Providers are either disseminating the Contractor's or equivalent False Claims Act policies and procedures to the Participating 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, or person with beneficial ownership of more than 5% of the Contractor's equity who is:

(i) 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; 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 an employment, consulting, or any other agreement with a person who is:

(i) 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 where the Contractor is using such person for the provision of items or services that are significant and material to the Contractor's obligations to the Department; 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.

(3) Per the Federal Acquisition Regulation, "business concerns are affiliates of each other, if directly or indirectly, either one controls or has the power to control the other, or another concern controls or has the power to control both. In determining whether affiliation exists, consideration is given to all appropriate factors including common ownership, common management, and contractual relationships; *provided* that restraints imposed by a franchise agreement are not considered in determining whether the franchisor controls or has the power to control the franchisee, if the franchisee has the right to profit from its effort, commensurate with ownership, and bears the risk of loss or failure. Any business entity may be found to be an affiliate whether or not it is organized for profit or located in the United States."

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

(3) 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), and (3), 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), and (3) 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), and (3) are not found in the database searches, the Contractor is required to determine if the individual is 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. Affiliate is defined in Article 6.3.1(A)(3)(i) of this Contract.

(1) The Contractor may provide the Department's Prohibited Affiliation Attestation Form to the individuals listed in Article 6.3.2(B)(1), (2) and (3). 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), and (3) 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) and (3) 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 Subcontracted Administrative Functions

(A) In the event that the Contractor has entered into a Subcontract with an entity that will be performing administrative functions that are significant and material to the Contractor's

obligations under this Contract, the Contractor shall ensure that Subcontractor does not have a prohibited affiliation of the type described in Section 6.3.1(A)(1), (2), and (3).
(B) The Contractor shall conduct the database searches and shall obtain attestations for individuals performing administrative functions locally to determine if any of the individuals are 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.

(C) The Contractor shall report any prohibited affiliation in accordance with Article 6.3.4.

(D) If the local Subcontractor has a parent entity, the Contractor shall require the parent entity to submit a letter to the Contractor regarding whether any of its individuals listed in Article 6.3.2(B)(1)(2) and (3) has a prohibited affiliation. The Contractor shall keep the original copy of the letter. If the letter states that the Subcontractor has a prohibited affiliation, the Contractor shall electronically submit a copy of the letter to the Department within 30 calendar days after the Contractor received the letter.

6.3.4 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 6.3.1(A)(1), (2), or (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 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.

(B) 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 Participating 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 CHIP 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 CHIP 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) Within 90 days of 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.

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 Action, Medical Necessity Denials

7.1 Service Authorization and Notice of Action

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.

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 Action 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 three working days 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 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 Action. The Contractor is required send out a Notice of Action 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 Action. The Contractor shall notify the requesting Provider and mail a Notice of Action 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 Action; or

(2) Five days before the date of the Action if the Contractor has facts indicating that the Action 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 Action 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 CHIP services by another local jurisdiction; or

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

7.2 Other Actions Requiring Notice of Action

7.2.1 Action to Deny Payment in Whole or Part for a Service

(A) The Contractor shall notify 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 Action at the time of the Action 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 Action 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 CHIP 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 CHIP eligible.

7.2.2 Action Due to Failure to Provide Covered Services in a Timely Manner

Any failure of the Contractor's Participating Providers to provide services in a timely manner constitutes an Action. The Contractor shall provide a Notice of Action 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 Action 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 Action. The Contractor shall provide a Notice of Action to the Enrollee 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 Enrollee 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 Action and the Enrollee is allowed to file a request for a State fair hearing as the Enrollee 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 Action due to failure to resolve an Appeal within the required timeframe, the Contractor shall include in the Notice of Action 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 Action a copy of the request form for a State fair hearing that the Enrollee can submit to request a State fair hearing.

7.3 Required Content of Notice of Action

7.3.1 Generally

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

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

(1) The Action the Contractor has taken or intends to take;

(2) The reason for the Action;

(3) The date the Action will become effective when the Action is to terminate, suspend, or reduce a previously authorized Covered Service;

(4) The Enrollee's or Provider's right to file an Appeal of the Action with the Contractor;

(5) The procedures for filing an Appeal;

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

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

(8) 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)(7), and 431.230(b); and

(9) 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 Action 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 Action; or

(ii) If the Enrollee is requesting continuation of disputed services pending resolution of an Appeal of an Action 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 Action; or

(b) by the intended effective date of the Contractor's proposed action.

7.3.2 Attachment to Notice of Action –Written Appeal Request Form

(A) The Contractor shall develop and include as an attachment to the notice of Action an Appeal Request form that Enrollees may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Enrollee 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 Enrollees 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 Enrollee may request to complete the Appeal Request form and how to request the assistance; and

(4) Include a reminder that if the Enrollee 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 Enrollees or Providers 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/CHIP 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 Enrollees that includes:

(1) a Grievance process whereby an Enrollee, or Provider acting on behalf of an Enrollee, may communicate a Grievance;

(2) an Appeals process whereby an Enrollee, or Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal of an Action, and

(3) procedures for an Enrollee, or a Provider acting on behalf of an Enrollee, 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.

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 Action are treated as an Appeal, to establish the earliest possible filing date for the Appeal;

(2) Ensure that the Enrollee or Provider 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 Enrollee or the Provider requests an expedited resolution to the Appeal. These requests do not require a follow-up written request;

(3) Provide the Enrollee reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited Appeal resolution; and

(4) Provide the Enrollee 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; and

(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

(A) An Enrollee or the Enrollee's legally authorized representative may file an Appeal; or

(B) A Provider may file an Appeal.

8.3.2 Timing

(A) The Enrollee or Provider may file an Appeal of an Action within 90 calendar days from the date on the Contractor's Written Notice of Action; or

(B) If the Action 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 Action; or

(2) the intended effective date of the Contractor's proposed Action.

8.3.3 Procedures

(A) The Enrollee or the Provider may file an Appeal either orally or in writing.

(B) Unless the Enrollee or a Provider 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 Enrollee does not follow-up with a written, signed Appeal the Contractor has no further obligation to take action on the Enrollee's Appeal.

(C) A Provider may file the written, signed Appeal on behalf of the Enrollee and shall include the Enrollee's signed written consent.

(D) If an Enrollee or Provider requests an Appeal orally, the Contractor shall immediately inform the Enrollee or Provider 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.

(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 Enrollee the process that must be followed to resolve the Appeal.

(G) The Contractor shall provide the Enrollee reasonable opportunity to present evidence, allegations of facts or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited Appeal resolution.

(H) The Contractors shall provide the Enrollee and the Enrollee's 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.

(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.

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 Enrollee 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 Enrollee's interest.

(C) If the Contractor extends the time frame, and the extension was not requested by the Enrollee, the Contractor shall give the Enrollee written notice of the reason for the delay.

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. 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 Enrollee, 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 Action;

(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 State fair hearing; or

(ii) the request form for an expedited State fair hearing that the Enrollee 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 Enrollee has an expedited Appeal.

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 or health or ability to attain, maintain or regain maximum function; or

(2) A Provider indicates that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function.

8.4.2 Authority to File

The Enrollee or a Provider 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 Enrollee or Provider may file an Appeal of an Action within 90 days from the date on the Contractor's Notice of Action;

(B) If the Action 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 Action; or

(2) by the intended effective date of the Contractor's proposed Action.

8.4.4 Procedures for an Expedited Appeal

(A) When an Enrollee or Provider requests an expedited resolution of an Appeal, the Contractor shall inform the Enrollee or Provider of the limited time available for the Enrollee to present evidence and allegations of fact or law 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, 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; 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.

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 three working days 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 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).

(C) If the Contractor extends the timeframe and the extension was not requested by the Enrollee the Contractor shall give the Enrollee written notice of the reason for the delay.

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 Action 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 Action; or

(ii) by the intended effective date of the Contractor's proposed Action; 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;

(3) a State fair hearing officer issues a hearing decision adverse to the Enrollee; or

(4) the time period of service limits of a previously authorized service has been met.

(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 Action, the Contractor may 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 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.

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

(B) The Contractor shall provide notification to Enrollees and Providers that the final decision of the Contractor may be appealed to the Department and shall give to the Enrollee and Provider the Department's form to request a State fair hearing. The Contractor shall inform the Enrollee and Provider the time frame for requesting a State fair hearing as follows:

(1) The Department permits the Enrollee (or the Enrollee's legal guardian or representative), consistent with Utah Administrative Code R410-14-1, *et seq*., to request a state fair hearing within 30 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 Enrollee or Provider 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 Enrollee 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.

(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 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; 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) a Grievance regarding denial of a request for an expedited resolution of an Appeal; or

(ii) a Grievance that involves clinical issues.

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 45 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.

(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 give the Enrollee written notice of the reason for the delay.

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 maintain all documentation relating to Appeals which includes, but is not limited to the following:

(1) written Notices of Action;

(2) 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

(3) copies of written standard Appeal requests;

(4) copies of written notices of denial of requests for expedited Appeal resolution;

(5) date of acknowledgement of written standard Appeal requests and method of

acknowledgment (orally or in writing);

(6) copies of written notices when extending the time frame for adjudicating standard or expedited Appeals when the Contractor initiates the extension;

(7) copies of written Notice of Appeal Resolution; and

(8) 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) date the Grievance was received;

(2) date and method of acknowledgement (orally or in writing);

(3) name of the person taking the Grievance;

(4) date of resolution and summary of the resolution;

(5) name of person resolving the Grievance; and

(6) 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 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 Participating 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 Participating 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 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 Participating Providers.

9.2 Participating 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; and

(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.

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, disability, or age.

(B) The nondiscrimination coordinator may also handle Grievances regarding the violation of other civil rights (sex and religion) 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, disability, or age.

10.1.2 General Standards

(A) The Contractor must have sufficient operating staff to comply with the terms of this Contract. At minimum, the Contractor must be able to identify qualified staff in the following areas:

(1) Executive management with clear oversight authority for all other functions;

(2) Medical Director's Office;

(3) Accounting and Budgeting function

(4) Member Services Function

(5) Provider Services Function

(6) Medical Management function, including quality assurance and utilization review;

(7) Enrollee and Provider complaint and grievance resolution function;

(8) Management of Contractor's information system.

(B) The Contractor shall plan for increased workload during periods of increased CHIP marketing and outreach.

10.1.2 Member Services Function

(A) The Contactor shall operate a Member Services function during 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 Contractor's Health Plan and its CHIP managed care policies and provide training, as needed

10.1.3 Provider Services Function

(A) The Contractor shall operate Provider Services function during 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 CHIP rules and regulations that shall enable Providers to appropriately render services to Enrollees;

(2) assisting Providers to verify whether an individual is enrolled with the Contractor's Health Plan;

(3) assisting Providers with prior authorizations and referral protocols;

(4) assisting Providers with claims payment procedures; and

(5) Fielding and responding to Provider questions and the Grievance and Appeals System.

10.1.4 Contractor Licensure

Contractor shall be licensed with the Utah Department of Insurance. The Contractor shall maintain such licensure through the duration of the Contract and shall immediately notify the Department in the event that its license is invalidated.

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) Payment for services provided by the Contractor if the Contractor received payment from the Department for the services or if a Participating Provider fails to receive payment from the Contractor.

(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 Participating 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 Contractor's 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 Participating

Providers and receive Covered Services.

(B) Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the patient, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality, and the patient is advised that a free interpreter is available.

(C) The Contractor shall ensure that its Participating 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.

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.

(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 Participating Providers which respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Participating Providers. Culturally competent care is care given by a Participating 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 Participating Providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to Participating 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 ensure access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities.

(B) The Contractor shall implement procedures to coordinate the services the Contractor furnishes to the Enrollee with the services the Enrollee receives from any other MCO, PIHP, or PAHP or Fee-For-Service Medicaid.

(C) 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.

(D) The Contractor's Participating 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.

(C) The Contractor shall allow Enrollees the opportunity to select a participating Primary Care Provider.

(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.

10.4 Billing Enrollees

10.4.1 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 Participating Providers to an Enrollee accepted by that Participating 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.

10.4.2 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.

(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.

10.4.3 Prohibition on Holding Enrollee's CHIP Card

The Contractor or its Participating Providers shall not hold the Enrollee's CHIP card as guarantee of payment by the Enrollee, nor may any other restrictions be placed on the Enrollee.

10.4.4 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.

10.5 Survey Required

10.5.1 General Requirements

(A) Surveys shall be conducted of Contractor's Enrollees that shall include questions about Enrollee's perceptions of access to and the quality of care received through the Contractor. The survey process, including the survey instrument, shall be standardized and developed by the Department.

(B) The Department shall analyze and publish the results of the surveys.

(C) The Contractor shall review the results of the surveys, identify areas needing improvement, outline action steps, and execute those actions. (See Attachment D)

Article 11 Measurement and Improvement Standards

11.1 Participating Provider Practice Guidelines

11.1.1 Participating Provider Practice Guidelines, General Standards

(A) The Contractor and its Participating 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 Participating 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.

11.2 Quality Assessment and Performance Improvement Program

11.2.1 Quality Assessment and Performance Improvement, Generally

(A) The Quality Assessment and Performance Improvement Program shall include a policymaking body which oversees the Quality Assessment and Performance Improvement Program, 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.

(B) The Contractor shall establish an ongoing quality assessment and performance improvement program for the services it furnished to Enrollees. 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.

11.2.2 Basic Elements of Quality Assessment and Performance Improvement Programs

(A) At minimum, the Contractor shall comply with the following requirements:

(1) Conduct PIPs that are 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 health outcomes and Enrollee satisfaction;

(2) Submit performance measurement data;

(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 the quality assessment and performance improvement program.

11.2.3 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.

11.2.4 Required Areas and Reporting of Performance Improvement Projects

(A) The Contractor shall have ongoing PIPs that focus on clinical and non-clinical areas, and that involve the following:

(1) Measurement of performance objectives using objective quality indicators;

(2) Implementation of system interventions to achieve improvement in quality;

(3) Evaluation of effectiveness of the interventions; and

(4) Planning and initiation of activities for increasing or sustaining improvement.

(B) The Contractor shall report the status and results of each project, including those required by CMS, to the Department as requested.

(C) Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. The Department may also, at its discretion, set up a timeframe and deadline for the Contractor to complete a PIP.

11.2.5 HEDIS and Consumer Satisfaction Surveys

(A) Audited Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance measures shall be reported as set forth in Utah Administrative Code R428-12-1, *et seq.*, and R428-13-1, *et seq*.

(B) The Contractor shall assign a staff member to attend an annual HMO Advisory Committee meeting as convened by the Office of Health Care Statistics to discuss the HEDIS reviews and consumer satisfaction survey results.

(C) For purposes of HEDIS measures and consumer satisfaction surveys, the calculations and results shall include both Traditional and Non-Traditional Enrollees.

(D) In the event that the Contractor experiences a 10 percentile decline in its HEDIS or CAHPS measures from the previous year compared to the NCQA Quality Compass for Medicaid, the Department will require the Contractor to develop and implement a corrective action plan.

11.2.6 Future Performance Measures

The Contractor and the Department agree to work collaboratively to develop future quality measures. The Parties agree to negotiate, in good faith, a quality measures amendment to this Contract.

11.2.7 Emergency Room Services Quality Reporting

(A) By October 1, 2015, the Contractor shall inform the Department whether it intends to conduct audits and develop a differential payment model as allowed by Utah Code Ann. §26-18-408(2).

(B) If the Contractor exercises its discretion to conduct audits and pay via a differential payment system the Contractor shall provide the yearly report required by Utah Code Ann. §26-18-408(3)(a) to the Department by April 1, beginning April 1, 2016.

(C) The Contractor shall participate with the Department's Quality Committee in Developing the quality measures described in Utah Code Ann. §26-18-408(4), and shall submit the date upon a mutually agreed upon date.

Article 12 Payments

12.1 General Payment Provisions

12.1.1 Risk Contract

This Contract is a risk Contract.

12.1.2 Payment Methodology

(A) On or before the 10th day of each month, the Department shall pay to the Contractor the premiums due for each category shown for Enrollees in the Contractor's Health Plan for that month as determined by the Department from the Enrollment and reinstatement transmissions.

(B) The premium amounts will be those rates agreed upon by the Contractor and the Department and are found in Attachment F.

(C) The Contractor shall receive premium payments for Enrollees beginning the earlier of:

(1) the month of the Enrollee's application was submitted; or

(2) the month in which the Four Day Grace period is approved.

12.1.3 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.

12.1.4 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, Enrollee eligibility for CHIP, or computer error.

(B) The Contractor shall refund any overpayments to the Department within 30 calendar days of discovering an overpayment or being notified by the Department that overpayments are due. If the Contractor fails to refund an overpayment within 30 days, the Department shall deduct the overpayment from the Department's next payment(s) to the Contractor. If the Contractor disagrees with the Department's determination that an overpayment has been made, the Contractor may request a State fair hearing within 30 days of the Department's recoupment of the overpayment.

12.2.3 Prohibition on Balance Billing

The Contractor shall ensure its Participating Providers will not balance bill the Enrollee. The Contractor shall ensure that its provider consider the reimbursement from the Contractor's Health Plan, plus co-payments, deductibles and/or co-insurance as payment in full.

12.2.4 Department Retraction of Premiums

(A) The Department may retract a premium payment from the Contractor in the event that:

(1) the Enrollee changes Health Plans;

(2) the Enrollee becomes eligible for Medicaid; or

(3) an error made by the Department has resulted in an inappropriate Premium being paid to the Contractor.

12.3 Third Party Liability and Coordination of Benefits

12.3.1 Recovery of Third Party Liability, Generally

(A) 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.

(B) In the event that the Contractor collects Third Party Liability on a CHIP claim, the Contractor shall correct the Encounter Data it submitted to the Department for that claim to accurately reflect the Third Party Liability collection.

12.3.2 Notification to Department

If the Contractor discovers any Third Party Liability Coverage, the Contractor shall notify the Department via email within 10 days of the discovery.

12.5 Contractor's Payment Responsibilities

12.5.1 Covered Services Delivered by Non-Participating Providers but Paid by the Contractor

(A) The Contractor shall not be required to pay for Covered Services when the Enrollee receives the services from Non-Participating Providers, 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;

(3) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the Contractor's Participating Providers;

(4) Covered Services received between the Enrollee's effective date of eligibility but before the Enrollee reasonably could have known which Providers were Participating Providers.

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

12.5.2 Payment to Non-Participating Providers

(A) Payment by the Contractor to a Non-Participating 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; or

(2) The rate agreed to by the Contractor and the Provider.

12.5.3 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-Participating 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.

12.5.5 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 CHIP 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 CHIP 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.

12.5.6 Payments for Vaccines for Children

(A) The Contractor shall not reimburse Providers for the cost of vaccines that are purchased through the federal Vaccines for Children Program.

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

12.6 Enrollee Transition Between Health Plans or Fee-For-Service

12.6.1 Enrollee Transition, 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 Covered Services related to the hospital stay until discharged.

(B) If a CHIP Eligible Individual was Fee-For-Service when admitted to the hospital and becomes 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 Covered Services related to the Hospital stay until discharged.

(C) The Health Plan in which the individual is enrolled with when discharged from the Hospital is financially responsible for Covered Services provided to the Enrollee during the remainder of the month.

(D) If a Chip Eligible Individual was eligible for 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.

12.6.2 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 CHIP Eligible Individual by the Department and the CHIP 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 the Contractor if the client is enrolled with the Contractor's Health Plan at the time the equipment is ordered. If the client is Fee-For-Service at the time the equipment is ordered, the Department is responsible.

12.6.3 Department Acceptance of Contractor's Prior Authorization

For Covered Services other than inpatient, medical equipment, and organ transplantations, if authorization has been given for a Covered Service and an Enrollee transitions to Fee-For-Service prior to the delivery of such Covered Service, the Department shall be bound the Contractor's prior authorization until the Department has evaluated the Medical Necessity of the service and agrees with the Contractor's prior authorization or has made a different determination.

12.6.4 Pharmacy Prior Authorizations

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 by another Health Plan to an Enrollee in the Contractor's Health Plan 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.

12.6.5 Provision of Medical Information to Enrollee's Health Plan or the Department

When CHIP 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 CHIP 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, 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.

12.6.6 Acceptance of Pre-Enrollment Prior Authorization

For Covered Services other than inpatient, medical equipment and organ transplantations, if authorization has been given for a Covered Service and a CHIP Eligible Individual transitions between Health Plans or Fee-For-Service prior to the delivery of such Covered Service, the receiving Health Plan shall be bound by the relinquishing Health Plan's prior authorization for 90 days.

12.6.7 Enrollee Transition, Organ Transplantations

The Contractor shall honor prior authorizations for organ transplantations 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.

Article 13 Additional Recordkeeping and Reporting Requirements

13.1 Recordkeeping Requirements

13.1.1 Health Information Systems, General Requirements

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, Grievances and Appeals, and disenrollments for reasons other than loss of CHIP eligibility.

13.1.2 Accuracy of Data

(A) The Contractor shall ensure that the data received from Providers is accurate and complete by:

(1) verifying the accuracy of the reported data;

(2) screening the data for completeness, logic, and consistency; and

(3) collecting service information in standardized formats to the extent feasible and appropriate.

(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.

13.1.3 Medical Records

The Contractor shall require its Participating Providers to maintain a medical record keeping system that complies with state and federal law.

13.1.5 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 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 annually, 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).

13.2 Additional Reporting Requirements

13.2.1 Enrollment, Cost and Utilization Reports

(A) The Contractor shall submit Enrollment, Cost and utilization reports in an electronic format designated by the Department. The reports shall be in Excel, and the Contractor shall utilize the Excel template provided by the Department. The Contractor is not allowed to customize or change the format of this report. The template of the report can be found in Attachment E of this Contract. The Department may amend attachment E at its discretion.

(B) The Contractor shall certify, in writing, the accuracy and completeness, to the best of its knowledge, of all cost and utilization data provided to the Department on Attachment E.

(C) Two Attachment E reports shall be submitted covering the dates of service for each Contract year. The reports shall be submitted as follows:

(1) Attachment E is due May 1 for the preceding six month reporting period (July through December).

(2) Attachment E is due November 1 for the preceding 12 month reporting period (July through June).

(D) 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.

(E) The Contractor shall include claims detail supporting their Attachment E data.

13.2.2 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) A report of the number of organ transplants by type of transplant;

(2) A report of obstetrical information including:

(i) the total number of obstetrical deliveries by aid category grouping;

(ii) the total number of caesarean sections and total number of vaginal deliveries;

(iii) the total number of low birth weight infants; and

(iv) the total number of Enrollees requiring prenatal hospital admission.

(3) The Grievance and Appeals reports required by Article 8.7.1 of this Contract.

(4) The state requires the Managed Care Plans to submit semi-annual reports summarizing information on corrective actions taken on physicians who have been identified by the Managed Care Plans as exhibiting aberrant physician behavior.

(5) The Contractor shall submit a report describing the number of claims processed. The report will include the number of claims submitted, the number of clean claims submitted, the number of clean claims paid within 30 days, and the number of clean claims paid within 90 days. The report will also provide the percentage of clean claims paid within 30 days and the percentage of clean claims paid within 90 days.

13.2.4 Provider Network Reports

The Contractor shall submit a monthly electronic file of its Participating Provider network that meets the Department's provider file specifications and data element requirements to the Department.

13.2.5 Case Management Reports

The Contractor shall submit annual case management reports no later than August 1 of each year for the preceding fiscal year. (See Attachment D).

13.2.6 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.

13.2.7 Additional Reporting Requirements

(A) The Contractor shall submit the following reports on the dates listed. If the due date falls on a weekend or on a state holiday, the report shall be due the following business day:

(1) The Contractor shall submit immunization data to the Department. The report shall include Enrollee name, CHIP ID, type of immunization identified by procedure code, and date of immunization will be reported in accordance with the Encounter Data Technical Manual.

(2) The Contractor shall submit formally collected and audited HEDIS data to the Department. Audited HEDIS performance measures will cover services rendered during each calendar year and will be reported as set forth in state rule by the Office of Health Care Statistics or HEDIS measures will be calculated based on submitted encounter data by the Department.

(3) On a monthly basis, the Contractor shall submit to the Department income statements for the prior month including but not limited to the following: enrollments, revenue, and paid medical and pharmacy costs. The due date of this report is the last day of the month. For example, February's income statement will be due March 31.

(4) On a monthly basis, the Contractor shall submit to the Department a report describing the time it takes for Enrollees to be sent their ID cards. The report will detail the number of ID cards sent within the following time periods calculated in calendar days: 0-21 days; over 21 days; and not yet sent. It will also detail the overall average number of days. The number of days will be calculated starting the day the Contractor receives enrollment information from the Department and ending the day the Contractor sends the ID card. Reporting will occur in the second month after the Contractor receives the enrollment information. For example, the report for enrollees whose enrollment information was received by the Contractor in January would be reported in March to the Department. The due date for this report is the last day of the month.

(5) Upon request, the Contractor shall provide the Department its list of CHIP covered codes within two weeks of the request.

(6) The Contractor shall report quality measures as required by CMS and those measures designated by the Quality Improvement Council.

(7) Annually, on November 1, the Contractor shall submit a report showing when the appointment and waiting time benchmarks were not met for the year ended June 30.

13.2.8 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.

13.3 Encounter Data

13.3.1 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 physician 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 90 days of the date the Department sends notice that the Encounter is rejected. The Contractor shall submit corrected Encounter Data for all Encounters it discovers are incorrect within 90 days from the date of discovery.

(H) The Contractor shall submit Encounter Data for all services rendered to CHIP 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 CHIP enrollees provided under a Subcontract, capitation or special arrangement with another facility or program.

(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.

13.3.2 Encounter Data Certification

(A) By electronically submitting its Encounter Data to the Department, the Contractor is certifying that the Encounter Data in accordance with 42 CFR 438.606.

(B) By electronically submitting its Encounter Data to the Department, the Contractor ensures that the data has been certified by one of the following:

(1) the Contractor's Chief Executive Officer;

(2) the contractor's Chief Financial Officer; or

(3) an individual who has delegated authority to sign for, and who reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer.

(C) By electronically submitting the Encounter Data to the Department the Contractor ensures that the person certifying the encounter data attests to the completeness and truthfulness of the data and documents based on the person's best knowledge, information, and belief.

13.4 Disallowance of Claims

13.4.1 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 include but are not limited to claims which were duplicative, overpaid, or disallowed.

(B) The Contractor shall reverse the Encounter(s) for incorrectly paid claims or the claims within sixty (60) days of the date of the earlier of (1) the date of discovery of an incorrectly paid claim or (2) the date of the notice of 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 15.

Article 14 Compliance and Monitoring

14.1 Audits

14.1.1 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 Participating 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.

14.1.2 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.

14.1.3 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 CHIP 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.

14.1.4 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.

14.2 Department and Contractor Quality Control

14.2.1 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 14.2.1 shall be due on August 31 of each year.

14.2.2 Quality Monitoring by the Department

(A) The Department shall review, at least annually, the impact and effectiveness of the Contractor's quality assessment and performance improvement program. At least 60 days prior to the Department's review, the Contractor shall provide to the Department:

(1) the Contractor's most current written quality improvement program description;

(2) the Contractor's most current annual quality improvement work plan;

(3) the Contractor's most current quality improvement work plan evaluation;

(4) documentation of the Contractor's compliance with standards defined by the Department's quality monitoring strategy (found in Attachment D);

(5) all other information requested by the Department to facilitate the Department's review of the Contractor's compliance standards defined in the Department's quality strategy (found in Attachment D).

(B) All documents submitted to the Department pursuant to Article 14.2.2 shall provide evidence of a well-defined, organized program designed to improve client care.

(C) The Department's review of the impact and effectiveness of the Contractor's quality assessment and performance improvement program shall also include:

(1) The results of the Contractor's PIPs; and

(2) The Contractor's compliance with the Department's quality strategy (found in Attachment D).

14.3 External Quality Review

14.3.1 External Quality Review, Generally

(A) Pursuant to 42 CFR Part 438, Subpart E, the Department shall arrange for EQRs to assess Contractor's management of quality, timeliness, and access to Covered Services.

(B) The Contractor shall maintain, and make available to the EQRs, 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.

14.3.2 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.

14.3.3 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.

14.3.4 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 Department shall review requests from the Contractor for extensions of these timeframes and shall approve or disapprove the request.

Article 15 Corrective Action and Sanctions

15.1 Corrective Action Plans

15.1.1 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.

15.1.2 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 15.3 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.

15.1.3 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 15.3 of this Contract.

15.1.4 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.

15.2 Capitation Payment Suspension

15.2.1 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.

15.2.2 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.

15.3 Liquidated Damages

15.3.1 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 15.3.2 and Article 15.3.3 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 15.3 be more than $500,000 per calendar year.

(H) The Department's ability to assess liquidated damages under this Section 15.3 is limited to the Contractor. In no event will liquidated damages under this Article 15.3 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.

15.3.2 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) $1000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 13.3)or the Post Adjudication Pharmacy file (as required by Article 4.14.8);

(4) $1000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 13.3) or Post Adjudication History file (as required under Article 4.14.8);

(5) $2500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the time frames established under Article 11.2.5.

(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 14.1;

(8) $1000 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.

15.3.3 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 Participating 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.

15.4 Sanctions Allowed by Federal Law

15.4.1 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 CHIP 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 CHIP 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) 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.

15.4.2 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.

15.4.3 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 15.4.2. 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 15.4.2, 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.

15.4.4 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 CHIP operations only if it finds (through onsite survey, Enrollee complaints, financial audits, or any other means) 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.

15.4.5 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 CHIP 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.

15.4.6 Hearing on Temporary Management

The Department may not delay imposition of temporary management of the administration of the Contractor's CHIP operations to provide a hearing before imposing this sanction.

15.4.7 Duration of Temporary Management

The Department may not terminate temporary management of the administration of the Contractor's CHIP operations until it determines that the Contractor can ensure that the sanctioned behavior shall not recur.

15.4.8 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 16 Termination of the Contract

16.1 Automatic and Without Cause Termination

16.1.1 Termination Without Cause

(A) The Contractor may terminate this Contract without cause by giving the Department written notice of termination at least 60 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.

16.1.2 Termination for Failure to Agree Upon Rates

At least 60 days prior the end of each state fiscal year, or as otherwise determined by the Department, the Parties shall meet and negotiate in good faith the rates (Attachment F) applicable to the upcoming year. If the Parties do not agree upon future rates by the end of the Contract year, either Party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 days after receipt of the written notice of termination. A termination under this Section 16.1.3 shall not be considered a termination without cause.

16.1.3 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services 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) If the Contractor one of its Participating Providers, or other subcontractor becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor, the Participating Provider, or the Subcontractor.

(C) Upon termination of this contract, the Contractor must promptly supply to the Department all information necessary for the reimbursement of any claims not paid by the Contractor.

16.2 Termination of Contract With Cause

16.2.1 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 CHIP 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.

16.2.2 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 CHIP 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.

16.2.3 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.

16.3 Close Out Provisions

16.3.1 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 16.3 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 17 Miscellaneous Provisions

17.1 Additional Provisions

17.1.1 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.

17.1.2 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.

17.1.3 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 CHIP program in accordance with the requirements of Federal and State law.

17.1.4 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.

17.1.5 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.

17.1.6 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.

17.1.7 Surveys

All surveys required under this Contract shall be funded by the Contractor unless another source agrees to fund the survey.

17.1.8 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan and the Department's policies and procedures, the Provider Manuals and Medicaid Information Bulletins, as applicable, and shall ensure that the Contractor and its Participating 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.

17.1.9 Solvency Standards

Unless exempt, the Contractor agrees to meet the solvency standards required by 42 CFR 438.116(b)(1).

17.1.10 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.

17.1.11 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 directly 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 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 or underpaid 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.

17.2 Data Security Provisions

17.2.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any

database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

17.2.2 Network Security

(A) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall at all times maintain network security that at minimum, includes network firewall provisioning, intrusion detection and regular third party penetration testing.

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to 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 17.2.2(B)(1) or (2).

17.2.3 Data Security

(A) The Contractor shall protect and maintain the security of Confidential Data with protection that conforms to one of the following:

(1) 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 17.2.3(A)(1) or (2).

(B) The Contractor shall develop and use appropriate administrative, technical and physical security measures to preserve the confidentiality and integrity of all electronically maintained or transmitted Confidential Data. These security measures include, but are not limited to, maintaining up-to-date anti-virus software, maintaining systems with current security updates, and controlled access to the physical location of the hardware itself.

17.2.4 Data Transmission

The Contractor shall ensure that any transmission or exchange of Confidential Data with the Department shall take place via secure means, such as HTTPS or FTPS.

17.2.5 Data Storage

(A) The Contractor shall ensure that any Confidential Data will be stored, processed, and maintained solely on designated target servers and that no Confidential Data at any time will be processed on or transferred to any unencrypted portable or laptop computing device or any unencrypted portable storage medium.

(B) The Contractor shall ensure that any Confidential Data that is stored, processed, or maintained on a laptop, portable computing device, cell phone, or portable storage device shall be encrypted using no less than 128 bit key.

17.2.6 Data Re-Use

The Contractor shall ensure that any and all Confidential Data exchanged shall be used expressly and solely for the purposes of fulfilling this Contract and other purposes as required or permitted by law. Confidential Data shall not be distributed, repurposed or shaped across other applications, environments, or business units of the Contractor. The Parties acknowledge and agree that Contractor may use and exchange Confidential Information for purposes related to managing the healthcare needs of Enrollees, including quality improvement initiatives, health care operations, utilization management, and other Enrollee health management purposes.

17.2.7 Notification of Confidential Data Breach

The Contractor shall notify the Department when any Contractor system that may access, process, or store Confidential Data is subject to unintended access or disclosure. The Contractor shall notify the Department of such unintended access or disclosure within 48 hours of discovery of such access or disclosure.

17.2.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the Duty of Confidentiality found in Article 17.2.1 and the Confidential Data requirements found in Articles 17.2.2 through 17.2.7 to all Subcontractors used by the Contractor.

17.3.9 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.