UTAH DEPARTMENT OF HEALTH CONTRACT

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

1831204
Department Log Number

182700488
State Contract Number

1. CONTRACT NAME: The name of this contract is Prepaid Mental Health Plan - Utah County.

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

PAYMENT ADDRESS
UTAH CO SUBSTANCE ABUSE
151 S UNIVERSITY AVE #1500
PROVO UT, 84601

MAILING ADDRESS
UTAH CO SUBSTANCE ABUSE
151 S. University Ave Suite 3200
Provo UT, 84606

Vendor ID: 38213EB
Commodity Code: 20967

3. GENERAL PURPOSE OF CONTRACT: The general purpose of this contract is To enter into a Prepaid Mental Health Plan contract with the Utah County Department of Drug and Alcohol Prevention and Treatment to provide substance use disorder services under the Prepaid Mental Health Plan managed care program..

4. CONTRACT PERIOD: The service period of this contract is 11/01/2017 through 06/30/2022, unless terminated or extended by agreement in accordance with the terms and conditions of this contract.

5. CONTRACT AMOUNT: The DEPARTMENT agrees to pay $20,900,000.00 in accordance with the provisions of this contract.

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

CONTRACTOR

Richard Nance
[redacted]

DEPARTMENT

Medicaid and Health Financing
Managed Health Care
Karen Ford
[redacted]

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

Attachment A: Utah Department of Health General Provisions
Attachment B: Special Provisions
Attachment C: Covered Services
Attachment D: Quality
Attachment E: Payment Methodology
Attachment F: BAA Placeholder

8. 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.

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

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Contract with Utah Department of Health and UTAH CO SUBSTANCE ABUSE, **Log #** 1831204

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: [redacted] 23 Jan 18
[redacted] Nathan Ivie
Commission Chair
Date

STATE

By: [redacted] 2/6/2018
Shari A. Watkins, C.P.A.
Director, Office Fiscal Operations
Date

Attachment A: UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

SUB-RECIPIENT

1. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

s. "Subrecipient" means the person who delivers the services or goods described in the Contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. **PAYMENT**:

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

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

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

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

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

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

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

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

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

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

19. **INDEMNIFICATION**:

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

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

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

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

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

22. **TERMINATION AND DEFAULT**:

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

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

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

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

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

22.6. In the event of such termination, Subrecipient shall be compensated for services properly performed under the Contract up to the effective date of the notice of termination. Subrecipient agrees that in the event of such termination for cause or without cause, Subrecipient's sole remedy and monetary recovery from the State is limited to full payment for all work properly performed as authorized under the Contract up to the date of termination as well as any reasonable monies owed as a result of Subrecipient having to terminate

contracts necessarily and appropriately entered into by Subrecipient pursuant to the Contract. Subrecipient further acknowledges that in the event of such termination, all work product, which includes but is not limited to all manuals, forms, contracts, schedules, reports, and any and all documents produced by Subrecipient under the Contract up to the date of termination are the property of the State and shall be promptly delivered to the State.

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

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

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

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

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

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

25. PUBLIC INFORMATION: Subrecipient agrees that the Contract, related purchase orders, related pricing documents, and invoices will be public documents and may be available for public and private distribution in accordance with the State of Utah's Government Records Access and Management Act (GRAMA). Subrecipient gives the Department and the State of Utah permission to make copies of the Contract, related sales orders, related pricing documents, and invoices in accordance with GRAMA. Except for sections identified in writing by Subrecipient and expressly approved by the State of Utah Division of Purchasing and General Services, Subrecipient also agrees that Subrecipient's Proposal to the Solicitation will be a public document, and copies may be given to the public as permitted under

GRAMA. The Department and the State of Utah are not obligated to inform Subrecipient of any GRAMA requests for disclosure of the Contract, related purchase orders, related pricing documents, or invoices.

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

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

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

29. SECURE PROTECTION AND HANDLING OF STATE DATA:

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

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

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

information; and (d) not disclose any State Data received by it to any third parties, except as permitted by the Contract or otherwise agreed to in writing by the Department.

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

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

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

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

33. **WARRANTY OF GOODS**:

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

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

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

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

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

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

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

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

in the Contract, unless Subrecipient offers a prompt payment discount within its proposal or on its invoice. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

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

40. **STANDARD OF CARE:** The Services of Subrecipient and its Subcontractors shall be performed in accordance with the standard of care exercised by licensed members of their respective professions having substantial experience providing similar services which similarities include the type, magnitude, and complexity of the Services that are the subject of this Contract. Subrecipient shall be liable to the Department and the State of Utah for claims, liabilities, additional burdens, penalties, damages, or third party claims (e.g., another Subrecipient's claim against the State of Utah), to the extent caused by wrongful acts, errors, or omissions that do not meet this standard of care.

41. **RECORD KEEPING, AUDITS, & INSPECTIONS**:

    41.1. For financial reporting, Subrecipient shall comply with the Uniform Guidance and Generally Accepted Accounting Principles (GAAP).

    41.2. Subrecipient shall maintain or supervise the maintenance of all records necessary to properly account for Subrecipient's performance and the payments made by the Department to Subrecipient under the Contract. These records shall be retained by Subrecipient for at least six (6) years after final payment, or until all audits initiated within the six (6) years have been completed, whichever is later. Subrecipient agrees to allow, at no additional cost, the State of Utah, federal auditors, and the Department's staff, access to all such records. These records shall be retained by Subrecipient as required by GAAP, federal or state law, or specific program requirements, whichever is longer. Subrecipient agrees to allow, at no additional cost, the State of Utah, federal auditors, and Department staff, access to all such records.

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

    41.4. Subrecipient shall comply with federal and state regulations concerning cost principles, audit requirements, and contract administration requirements, including, but not limited to, the Uniform Guidance. Unless specifically exempted in the Contract's special provisions, Subrecipient must comply with applicable federal cost principles and Contract administration requirements if state funds are received. Counties, cities, towns, school districts are subject to the State of Utah Legal Compliance Audit Guide. Copies of required reports shall be sent to the Utah Department of Health, Office of Fiscal Operations P.O. Box 144002, Salt Lake City, Utah 84114-4002.

42. **EMPLOYMENT PRACTICES:** Subrecipient shall abide by the following employment laws, as applicable: (i)Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e) which prohibits discrimination against any employee or applicant for employment or any applicant or recipient of services, on the basis of race, religion, color, or national origin; (ii) Executive Order No. 11246, as amended, which prohibits discrimination on the basis of sex; (iii) 45 C.F.R. § 90 which prohibits discrimination on the basis of age; (iv) Section 504 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act of 1990, which prohibits discrimination on the basis of disabilities; (v) Utah Executive Order No. 2006-0012, dated December 13, 2006, which prohibits unlawful harassment in the work place; (vi) Utah Code Ann. § 26-38-1 *et. seq.*, Utah Indoor Clean Air Act which prohibits

smoking in enclosed public places; (vii) Utah Executive Order No. 2006-0012 which prohibits all unlawful harassment in any workplace in which state employees and employees of public and higher education must conduct business; (viii) 41 CFR part 60, Equal Employment Opportunity, and the Executive Order 11246, as amended by Executive Order 11375, which implements those regulations; (ix) 45 C.F.R. part 83, which prohibits the extension of federal support to any entity that discriminates on the basis of sex in the admission of individuals to its health manpower and nurse training programs; and (x) 40 U.S.C. §§ 3702 and 3704, as supplemented by Department of Labor regulations (29 C.F.R. part 5), Contract Work Hours and Safety Standards Act, for contracts that involve the employment of mechanics or laborers. Subrecipient further agrees to abide by any other laws, regulations, or orders that prohibit the discrimination of any kind of any of Sub recipient's employees.

43. **FEDERAL REQUIREMENTS:** Subrecipient shall abide by the following federal statutes, regulations and requirements, including, but not limited to (i) 2 C.F.R. § 200.326, Contract Provisions as applicable; (ii) 45 C.F.R. § 46, Protection of Human Subject in research activities; (iii) 45 C.F.R. part 84, prohibits discrimination of drug or alcohol abusers or alcoholics who are suffering from mental conditions from admission or treatment by any private or public hospital or outpatient facility that receives support or benefit from a federally funded program; (iv) 42 C.F.R. parts 2 and 2a which implements the Public Health Service Act, sections 301(d) and 543, which requires certain medical records that relate to drug abuse prevention be kept confidential when the treatment or program is directly or indirectly assisted by the federal government; (v) 42 U.S.C. §§ 7401-7971q., the Clean Air Act and 33 U.S.C. §§ 1251-1387, the Federal Water Pollution Control Act, and all applicable standards, orders or related regulations; (vi) 31 U.S.C. § 1352, Byrd Anti-Lobbying Amendment; (vii) 42 U.S.C § 4331, the National Environmental Policy Act of 1969; (viii) 2 C.F.R. § 200.322, Procurement of recovered materials which outlines section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act; (ix) 37 C.F.R. § 401, Rights to Inventions Made; (x) 42 C.F.R. part 50, Subpart B, Sterilizations; (xi) 42 C.F.R. part 50, Subpart C, Abortions and Related Medical Services; (xii) 59 FR 46266, Recombinant DNA and Institutional Biosafety; (xiii) 7 U.S.C. § 2131, Animal Welfare; (xiv) 42 C.F.R. part 92, Misconduct in Science; (xv) 42 U.S.C. §§ 4728-4763, Merit System Standards for governmental entities only; and (xvi) Subrecipient shall include in any contracts termination clauses for cause and convenience, along with administrative, contractual, or legal remedies in instances where subcontractors violate or breach contract terms and provides for such sanctions and penalties as may be appropriate.

44. **WAIVER**: A waiver of any right, power, or privilege shall not be construed as a waiver of any subsequent right, power, or privilege.

45. **ATTORNEY'S FEES:** In the event of any judicial action to enforce rights under this Contract, the prevailing party shall be entitled its costs and expenses, including reasonable attorney's fees incurred in connection with such action.

46. **SUBCONTRACTS & ASSIGNMENT:** Subrecipient shall not assign, sell, transfer, subcontract, or sublet rights or delegate responsibilities under the Contract, in whole or part, without the prior written consent of the Department. Subrecipient retains ultimate responsibility for performance of all terms, conditions and provisions of the Contract that are subcontracted or performed by a Subcontractor. When subcontracting, Subrecipient agrees to use written subcontracts that conform to federal and state laws. Subrecipient shall request Department approval for any assignment at least twenty (20) days prior to its effective date.

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

48. **SEVERABILITY**: The invalidity or unenforceability of any provision, term, or condition of the Contract shall not affect the validity or enforceability of any other provision, term, or condition of the Contract, which shall remain in full force and effect.

49. **SURVIVAL OF TERMS:** Termination or expiration of this Contract shall not extinguish or prejudice the Department's right to enforce this Contract with respect to any default or defect in the Services that has not been cured.

50. **NOTICE**: Notice shall be in writing and directed to the contact person listed on Contract Signature Page(s) of the Contract.

51. **ORDER OF PRECEDENCE**: The terms of the Contract shall be reasonably interpreted and construed to avoid any conflict among the provisions. If there is any conflict between the Contract's terms, the order of precedence (listed in order of descending precedence) among the terms is: (1) Contract Signature Page(s); (2) Department General Provisions; (3) Department Special Provisions; (4) Any other attachments.

52. **TIME IS OF THE ESSENCE**: The Services shall be completed by any applicable deadline stated in the Contract. For all Services, time is of the essence. Subrecipient shall be liable for all reasonable damages to the Department, the State of Utah, and anyone for whom the State of Utah may be liable as a result of Subrecipient's failure to timely perform the Services required under the Contract.

53. **DISPUTE RESOLUTION**: The Department and Subrecipient shall attempt to resolve contract disputes through available administrative remedies prior to initiating any court action. Prior to either party filing a judicial proceeding, the parties agree to participate in the mediation of any dispute. The Department, after consultation with the Subrecipient, may appoint an expert or panel of experts to assist in the resolution of a dispute. If the Department appoints such an expert or panel, Department and Subrecipient agree to cooperate in good faith in providing information and documents to the expert or panel in an effort to resolve the dispute.

54. **ENTIRE AGREEMENT:** This Contract constitutes the entire agreement between the parties and supersedes any and all other prior and contemporaneous agreements and understandings between the parties, whether oral or written.

(Revision date: Oct. 2017)

Attachment B – Special Provisions

Article 1: Introductory Provisions

1.1 Parties

(A) This Contract is between the State of Utah, acting by and through its Department of Health hereinafter referred to as "DOH" or "Department" and Utah County Department of Drug and Alcohol Prevention and Treatment hereinafter referred to as "Contractor." Together, the Department and Contractor shall be referred to as the "Parties."

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

1.2 Service Area

1.2.1 Service Area, Generally

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

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

1.2.2 Residency in Service Area

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

1.2.3 Mandatory/Voluntary Enrollment Service Areas

Medicaid Enrollees with the reported county code for Utah County are mandatorily enrolled in the Contractor's PMHP.

Article 2: Definitions

2.1 Contract Definitions

2.1.1 Definitions

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

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

health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

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.

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

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.

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

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

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

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

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

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

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

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

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

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

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 mental health services identified in Attachments B and C of this Contract which the Contractor is required to provide and pay for pursuant to the terms of this Contract.

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

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

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

1. placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;

2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

Federal Financial Participation or **FFP** means, in accordance with 42 CFR 400.203, the Federal Government's share of a state's expenditures under the Medicaid program.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Institutions for Mental Diseases or **IMD** means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an institution for mental diseases.

K Children means Enrollees identified in the 834 file as being in Rate Cell K.

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

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

Managed Care Entity or **MCE** means MCOs, PIHPs, PAHPs, PCCMs, and HIOs.

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

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

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

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

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

Medically Necessaryor Medical Necessity means Medically Necessary Service as defined by Utah Administrative Code R414-1-2(18).

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

MLR means Medical Loss Ratio as described in Article 12.5.

NCQA means the National Committee for Quality Assurance.

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

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

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

Notice of 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.

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.

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

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

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.

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

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

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

Prepaid Mental Health Plan or **PMHP** means a mental health and/or substance use disorder plan operated under the Department's freedom-of-choice waiver approved by CMS that allows the Department to require Medicaid Eligible Individuals in certain counties of the State to obtain Covered Services from specified contractors.

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

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

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

Quality Assessment and Performance Improvement Program or **QAPI** or **QAPIP** means the Contractor's plan to establish and implement an ongoing comprehensive quality assessment and

performance improvement program for the services it furnishes to its Enrollees in accordance with 42 CFR 438.330.

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

Rating Period means a period of 12 months selected by the Department for which the actuarially sound Capitation Rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a).
Readily Accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

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.

SAM means the System for Award Management database.

Service Area means the counties enumerated in Article 1.2 of this Contract.

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

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

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

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

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

State Match means the current percentage of the state of Utah's share of Medicaid expenditures as described by 42 CFR 433.10.

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

State Plan Services means Covered Services described by the State Plan.

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

Subcontractor means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the Department. A Network Provider is not a Subcontractor by virtue of the Network Provider's agreement with the Health Plan. This definition of Subcontractor applies to Attachment B, C, and D unless otherwise specified.
Suspended means, for purposes of Article 6 of this Contract that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

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

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

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

Waste means overutilization of resources or inappropriate payment.

Article 3: Enrollment Services

3.1 Marketing Activities

3.1.1 Marketing, Generally

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

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

3.1.2 Prohibited Marketing Activities

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

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

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

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

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

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

3.2.2 Department Approval

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

3.2.3 Specify Methods

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

3.2.4 Distribution of Marketing Materials

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

3.2.5 Marketing Activities Prohibited

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

3.3 Enrollment Process

3.3.1 Enrollment by the Department

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

3.3.2 Period of Enrollment

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

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

(C) The Contractor shall be responsible for payment of all Clean Claims for Covered Services rendered to an Enrollee for whom the Contractor has received a Capitation Payment. The

Contractor is responsible for payment even where an Enrollee changes their county of residence during the month that the Contractor received a Capitation Payment.

3.3.3 Retroactive Enrollment

The Contractor shall provide Covered Services to Enrollees dating back to the month in which a Potential Enrollee is determined to be eligible for Medicaid. This time period of retroactive eligibility may exceed 12 months, however, the Department shall pay up to 12 months of Capitation Payments to the Contractor and the Contractor shall be responsible for providing Covered Services during those 12 months.

3.3.4 Prohibition Against Conditions on Enrollment

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

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

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

3.3.5 Enrollment Process

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

3.4 Eligibility Transmission

3.4.1 Eligibility Transmission, Generally

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

(B) Critical Fields found in the Eligibility Transmission shall include: Enrollee's case number, case name, eREP identification number, name, date of birth, date of death, social security

number, gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, (including those for Indians) eligibility start date, third party liability coverage, county, address, phone number, and if applicable, the Enrollee's Provider under the Restriction Program.

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

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

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

3.4.2 Eligibility Transmission, Specific Types of Enrollees

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

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

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

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

3.4.3 Eligibility File, Contractor Responsibilities

(A) The Contractor shall be responsible for ensuring that it is using the most recent 834 file to determine eligibility.

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

3.5 Enrollee Information

3.5.1 General Enrollee Information

(A) The Contractor shall ensure that adequate supplies of the Contractor's handbook are provided to the state's mailing services.

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

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

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

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

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

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

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

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

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

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

(G) The Contractor shall notify its Enrollees that:

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

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

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

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

(I) The Contractor shall use the Department-developed definition for the following terms: appeal; co-payment; durable medical equipment; emergency medical condition; emergency medical transportation; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home health care; hospice services; hospitalization; hospital outpatient care; medically necessary; network; non-participating

provider; participating provider; plan; physician services; preauthorization; premium; prescription drug coverage; prescription drugs; primary care physician; PCP; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

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

3.5.2 Enrollee Information Requirements—Prevalent Language

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

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

3.5.3 Enrollee Information Requirements—Written Materials

(A) The Contractor's written materials shall:

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

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

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

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

(C) The Contractor shall:

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

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

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

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

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

3.5.4 Enrollee Handbook

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

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

(C) The Enrollee handbook shall contain information:

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

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

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

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

(5) which details that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees that the service is not covered by the Contractor and how they can obtain information from the Department about how to access those services;

(6) on the amount, duration, and scope of benefits available under the Contract in

sufficient detail to ensure that Enrollees understand the benefits to which they are entitled; and

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

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

(9) on how emergency care is provided;

(10) regarding what constitutes an Emergency Medical Condition;

(11) regarding what constitutes an Emergency Service;

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

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

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

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

(i) receive information on beneficiary and plan information;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(25) on how to exercise an Advance Directive, if the Contractor has any of the following in its network: hospitals, critical access hospitals, home health agencies, Providers of home health care, Providers of personal care services, hospices, and religious nonmedical health care institutions;

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

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

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

(29) any other content required by the Department.

3.5.5 Enrollee Handbook Dissemination

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

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

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

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

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

3.5.6 Network Provider Directory

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

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

(2) Street addresses;

(3) Telephone numbers;

(4) Website URLs, as appropriate;

(5) Specialties, as appropriate;

(6) Whether Network Providers will accept new Enrollees;

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

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

(B) The Contractor shall update the paper Network Provider directory at least monthly. The Contractor shall update the electronic Network Provider directory no later than 30 calendar days after the Contractor receives updated Provider information.

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

(D) The Contractor shall comply with the Network Provider directory requriements found in this Aritlce 3.5.7 by July 1, 2018.

3.5.7 Termination of Contracted Provider

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

3.5.8 Enrollee Handbook Review and Approval

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

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

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

3.6 Disenrollment

3.6.1 Disenrollment Initiated by Contractor

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

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 the State's Prepaid Mental Health Plan Waiver as promptly and continuously as is consistent with generally accepted standards of

medical practice.

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

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

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

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

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

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

4.1.2 Covered Services

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

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

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

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

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

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

4.2 Scope of Services

4.2.1 Scope of Covered Services

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

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

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

(D) The services provided by Contractor shall be delivered in compliance with the requirements of Subpart K of 42 CFR Part 438 insofar as applicable.
(E) The Contractor shall provide the Department with non-quantitative treatment limitation assessment tools, surveys or any corrective action plans related to compliance with the Mental Health Parity and Addition Equity Act of 2008 and all related regulations as requested by the Department within the timeframes requested by the Department.

4.2.2 Changes to Benefits

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

4.2.3 Court and Administrative Orders Regarding Benefits

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

4.3 Covered Services—Emergency Services

4.3.1 Emergency Services Generally

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

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

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

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

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

4.3.2 Emergency Services, 24 Hours

The Contractor shall have the capability to provide or arrange for all Emergency Services, 24 hours each day, seven days a week. On a 24 hour basis, the Contractor shall ensure that Enrollees have access by telephone to a live voice or answering machine which will immediately page an on-call mental health professional.

4.3.3 Emergency Services in an Outpatient Hospital

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

4.3.4 Payment Liability for Emergency Services

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

4.3.5 Payment Liability in the Absence of a Clinical Emergency

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

4.3.6 Payment Liability for Referrals

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

Article 5: Delivery Network

5.1 Availability of Services

5.1.1 Network Requirements

(A) The Contractor shall maintain and monitor a network of appropriate, Network Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract. In establishing and maintaining the network of Network Providers the Contractor must consider the following:

(1) The anticipated Medicaid enrollment;

(2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's Service Area;

(3) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the contracted Medicaid services;

(4) The number of Network Providers who are not accepting new Medicaid patients; and

(5) The geographic location of Network Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Medicaid Enrollees with disabilities.

(B) The Contractor shall ensure that each Enrollee is able to choose his or her network Provider

to the extent possible and appropriate.

5.1.2 Second Opinions

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

5.1.3 Out of Network Services

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

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

5.1.4 Timely Access

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

5.1.5 Timely Access Monitoring

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

5.2 Subcontracts and Agreements with Providers

5.2.1 Subcontracts, Generally

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

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

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

(2) The contract or written arrangement between the Contractor and the Subcontractor must either provide for the revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determines that the Subcontractor has not performed satisfactorily.

(C) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions.

(D) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to agree that the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract.

(E) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to make available, for the purposes of an audit, evaluation, or inspection by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Enrollees.

(F) Contracts between the Contractor and any Subcontractor shall require the Subcontractor to agree that the right to audit by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(G) Contracts between the Contractor and any Subcontractor shall require that if the Department, CMS, or the Department of Health and Human Services Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

5.2.2 Agreements with Providers and Subcontractors

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

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

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

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

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

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

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

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

5.2.3 Other Network Provider Requirements

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

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

(C) All of the Contractor's Network Providers shall be aware of the Contractor's Quality Assessment and Performance Improvement Plan (QAPIP) and activities. All of the Contractor's agreements with Network Providers shall include a requirement securing cooperation with the Contractor's QAPIP and activities and shall allow the Contractor access to the medical records of Enrollees being treated by Network Providers.

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

(E) By January 1, 2018, the Contractor shall ensure all of its Network Providers are either

enrolled with the Department as a Fee-For-Service provider or are enrolled with the Department as a "limited enrollment provider."

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

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

After January 1, 2018, the Contractor shall only make payment to a Provider who is enrolled with the Department as a full or limited Medicaid Provider.

5.3.2 Network Provider Selection, Generally

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

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

5.3.3 Credentialing and Re-Credentialing Policies and Procedures

(A) Pursuant to 42 CFR 438.214(b)(2), the Contractor shall have written policies and procedures for credentialing potential Network Providers and re-credentialing Network Providers. The Contractor's written policies and procedures shall follow the Department's policies that require:

(1) Network Provider completion of Contractor written applications;

(2) Procedures for assuring that potential and current Network Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);

(3) Primary source verification of licensure and disciplinary status by the State of Utah and other States;

(4) Procedures for viewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension, or exclusion.

5.3.4 Timeframe for Re-Credentialing

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

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

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

5.3.5 Notifications

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

5.3.6 Documentation

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

5.3.7 Non-Inclusion of Providers

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

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

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

5.3.8 Nondiscrimination

(A) Consistent with 42 CFR 438.214 and 42 CFR 438.12, the Contractor's Provider selection policies and procedures must not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment.
(B) Pursuant to 42 CFR 438.12, the Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of that Provider's license or certification under applicable State law, solely on the basis of the Provider's license or certification. This may not be construed to mean that the Department:

(1) Requires the Contractor to Contract with Providers beyond the number necessary

to meet the needs of its Enrollees;

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

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

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

5.3.9 Federally Qualified Health Centers

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

(B) If the Contractor subcontracts with an FQHC the Contractor shall reimburse the FQHC an amount not less than what the Contractor pays comparable Providers that are not FQHCs.

5.4 Payment of Provider Claims

5.4.1 General Requirements

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

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

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

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

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

5.5 Prohibitions on Payment

5.5.1 Availability of FFP

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

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

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

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

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

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

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

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

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

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

(B) The Parties understand and agree that the Department must ensure that no payment is made to a Network Provider other than by the Contractor for Covered Services, except when these payments are specifically required to be made by the Department in Title XIX of the Social

Security Act, in 42 CFR, or when the Department makes direct payments to Network Providers for graduate medical education costs approved under the State Plan.

5.6 Network Provider Guidelines

5.6.1 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall develop or adopt practice guidelines consistent with current standards of care. The practice guidelines shall meet the following requirements:

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

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

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

(4) Guidelines shall be reviewed and updated periodically as appropriate.

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

(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.

Article 6: Program Integrity Requirements

6.1 Fraud, Waste and Abuse

6.1.1 Generally

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

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

(C) The Contractor's compliance plan shall include a description of the Contractor's Fraud,

Waste, and Abuse case management tracking system. If the Contractor does not have a Fraud, Waste, and Abuse case management tracking system the Contractor shall describe its plans to develop such a tracking system.

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

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

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

6.1.2 Specific Requirements for Contractor's Management Arrangements or Procedures

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

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

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

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

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

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

(6) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract,

(7) As detailed in Article 6.1.6 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 documentation of the sampling methodology and the schedule for conducting the verifications; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Nature of complaint;

(5) Approximate dollars involved, if applicable and

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

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

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

6.1.4 Reporting Recipient-Related Fraud, Waste, and Abuse

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

6.1.5 Obligation to Suspend Payments to Providers

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

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

6.1.6 Service Verification

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

(1) annually, the Contractor shall randomly select a minimum of 50 individual Enrollees

who received a Covered Service during the state fiscal year for service verification; and

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

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

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

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

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

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

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

6.2 False Claims Act

6.2.1 False Claims Act, Generally

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

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

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

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

6.2.2 Information Required in False Claims Act Policies

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

in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs.

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

6.2.3 Dissemination of False Claims Act Policies and Procedures

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

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

(C) The Contractor shall use all reasonable efforts, including provider attestations, to ensure that its Network Providers are either disseminating the Contractor's or equivalent False Claims Act policies and procedures to the Network 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, a Subcontractor as governed by 42 CFR 438.230, or person with beneficial ownership of more than 5% of the Contractor's equity who is:

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

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

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

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

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

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

6.3.2 Screening for Prohibited Affiliations

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

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

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

(2) a Subcontractor as governed by 42 CFR 438.230;

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

(4) Network Providers; or

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

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

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

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

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

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

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

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

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

(G) If an entity other than the Contractor (for example, the Board of Directors) has the authority to enter into a relationship described in Article 6.3.2(B)(1), (2), (3), (4) and (5) of this Contract, then the Contractor or the other entity shall conduct the required database searches and obtain the

requisite attestations. Thereafter the other entity or the Contractor shall conduct the monthly searches to ensure that those individuals have not been added to the databases. The party conducting the search shall keep records showing that these monthly searches were conducted.

6.3.3 Reporting Prohibited Affiliations

(A) In the event that the Contractor determines that it is not in compliance and has entered into a prohibited affiliation of the type described in Article 6.3of 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 is an affiliate, as defined by the Federal Acquisition Regulation, of a person who has been disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall provide an electronic copy of the attestation form to the Department no later than 30 calendar days from the date of the individual providing the attestation to the Contractor.

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

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

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

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

6.4 Excluded Providers

6.4.1 Definition of Excluded Providers

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

6.4.2 Screening for Excluded Providers

(A) The Contractor shall maintain written policies and procedures for conducting routine searches of the SAM and LEIE database 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 SAM 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 SAM 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, the Contractor may delegate any of the following monthly searches:

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

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

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

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

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

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

6.4.3 Excluded Provider Payment Prohibition

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

6.5 Disclosure of Ownership and Control Information

6.5.1 Disclosure Information

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

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

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

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

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

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

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

(3) Managing Employees shall disclose:

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

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

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

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

Person with an Ownership or Control Interest in the Other Disclosing Entity (or Fiscal Agent or Managed Care Entity).

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

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

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

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

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

6.5.2 Reporting Timeframes

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

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

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

(3) Upon renewal or extension of the Contract.

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

Interest.

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

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

6.5.3 Consequences for Failure to Provide Disclosures

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

6.6 Disclosure of Provider Incentive Plans

6.6.1 Generally

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

6.6.2 Prohibition

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

6.6.3 Reporting Requirements

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

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

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

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

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

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

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

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

6.6.4 Substantial Financial Risk

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

6.6.5 Information to Enrollees

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

Article 7: Authorization of Services, Notices of 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 Request

(A) If the Contractor denies a Service Authorization Request, or authorizes a requested service in an amount, duration or scope that is less than requested, the Contractor shall make the decision and give a Notice of 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 and the Provider on the day that the time frame expires.

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

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 Medicaid 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 provide a written Notice of Action to 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; or

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

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

Any failure of the Contractor's Network Providers to provide services in a timely manner constitutes an 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 standards for offering face-to-face appointment waiting times found in Article 10.4.

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 Aggrieved Party 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, Aggrieved Party 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 an Aggrieved Party is allowed to file a request for a State fair hearing as the Aggrieved Party has already exhausted the Contractor's internal appeals process. The Contractor may not require the Aggrieved Party 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 Medicaid State fair hearing that the Aggrieved Party can submit to request a State fair hearing.

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

7.3 Required Content of Notice of Action

7.3.1 Generally

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

(B) All written Notices of 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 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 Aggrieved Parties may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Aggrieved Party chooses to submit a written request for an expedited Appeals resolution, even though an oral request is all that is required. The form shall:

(1) Provide a prompt mechanism (through the use of check boxes or other means) for Aggrieved Parties to:

(i) request expedited Appeal resolution if they chose to submit a written request for an expedited Appeal resolution; and

(ii) request continuation of disputed services, if applicable;

(2) Provide a statement that if continuation of disputed services is requested when a previously authorized service is terminated, suspended or reduced, that the Enrollee agrees that the Contractor may recover from the Enrollee the cost of the services furnished while the Appeal is pending if the Appeal decision is adverse to the Enrollee, to the extent that the services were furnished solely because of the requirements of this Contract that are based on federal regulation in 42 CFR 438.420;

(3) Summarize the assistance available to the Aggrieved Party may request to complete the Appeal Request form and how to request the assistance; and

(4) Include a reminder that if the Aggrieved Party 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 90 days from the date of the Notice of Action.

(B) When the Contractor is required to inform Aggrieved Parties of their State Fair hearing rights, the Contractor shall not attach its own Appeal Request form but shall, instead, attach the State's request form for a Medicaid State fair hearing.

Article 8 Grievance and Appeals Systems

8.1 Overall System

8.1.1 General Requirements

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

(1) a Grievance process whereby an Aggrieved Party, may communicate a Grievance;

(2) an Appeals process whereby an Aggrieved Party may file an Appeal of an Action, and

(3) procedures for an Aggrieved Party to access the State's fair hearing system.

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

(C) To the extent that any written notice is required by Articles 8.1, 8.2, 8.3, 8.4 and 8.5, if the Enrollee is not the Aggrieved Party, the Contractor shall also provide a copy of notices to the Enrollee.

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

(A) The Contractor's process for Appeals shall:

(1) Provide that oral inquiries seeking to appeal an Action are treated as an Appeal, to establish the earliest possible filing date for the Appeal;

(2) Ensure that the Aggrieved Party understands that the oral Appeal shall be confirmed in writing within 90 days from the date of the Notice of Action, unless the Aggrieved Party requests an expedited resolution to the Appeal. These requests do not require a follow-up written request;

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

(4) Provide the Aggrieved Party, before and during the appeals process, the opportunity to examine the Enrollee's case file as allowed by law, 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

An Aggrieved Party or an Enrollee's legally authorized representative may file an Appeal.

8.3.2 Timing

(A) The Aggrieved Party 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 Aggrieved Party 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 Aggrieved Party may file an Appeal either orally or in writing.

(B) Unless the Aggrieved Party 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 90 days from the date on the Notice of Action. 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) If an Aggrieved Party requests an expedited Appeal orally, the Contractor shall immediately inform the Aggrieved Party that the oral filing of an Appeal must be followed with a written, signed appeal within 90days from the date of the Notice of Action.

(D) 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.

(E) The Contractor shall acknowledge receipt of the Appeal either orally or in writing and explain to the Aggrieved Party the process that must be followed to resolve the Appeal.

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

(G) The Contractors shall provide the Aggrieved Party the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(H) 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.

(I) 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 Aggrieved Party requests the extension; or

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

(C) If the Contractor extends the time frame, and the extension was not requested by the Aggrieved Party, the Contractor shall give the Aggrieved Party 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 Aggrieved Party, the Contractor shall include the following in the written Notice of Appeal Resolution:

(i) the right to request a State fair hearing and how to do so;

(ii) the right to request continuation of disputed services if the Appeal decision is to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider and the original period covered by the original authorization has not expired;

(3) how to request continuation of disputed services;

(4) a statement that the Enrollee may be liable for the cost of disputed services provided if the State fair hearing decision upholds the Contractor's 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 request form for a standard Medicaid State fair hearing; or

(ii) the standard request form for an expedited State fair hearing if the Aggrieved Party 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 Aggrieved Party may file an expedited Appeal request either orally or in writing. Oral requests for expedited Appeal do not require a follow-up written request.

8.4.3 Timing

(A) The Aggrieved Party 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 Aggrieved Party 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 Aggrieved Party 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.

(F) If the Enrollee is not the Aggrieved Party, the Contractor shall also provide the notices described in this Article 8.4.4 to the Enrollee.

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 they 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 Aggrieved Party requests the extension; or

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

(C) If the Contractor extends the timeframe and the extension was not requested by the Aggrieved Party the Contractor shall give the Aggrieved Party 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 Aggrieved Party withdraws the Appeal;

(2) ten days pass after the Contractor mails written Notice of Appeal Resolution that is adverse to the Aggrieved Party and within that 10 day time period, and the Aggrieved Party 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 Aggrieved Party; 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 Aggrieved Party has exhausted the Contractor's Appeal process and a final decision has been made, the Contractor shall provide written notification to the party or parties who initiated the Appeal of the outcome and explain in clear terms a detailed reason for the denial.

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

(1) The Department permits the Aggrieved Party(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, the Aggrieved Party, as well as the Enrollee and his or her representative who may include legal counsel, a relative, a friend or other spokesman, or the representatives of a deceased Enrollee's estate.

(D) The parties to a State fair hearing shall be given an opportunity to examine at a reasonable time before the date of the hearing and during the hearing, the content of the Enrollee's case file and all documents and records to be used by the Contractor at the hearing.

(E) The parties to the State fair hearing shall be given the opportunity to:

(1) bring witnesses;

(2) establish all pertinent facts and circumstances;

(3) present an argument without undue interference; and

(4) question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

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

(G) The Aggrieved Party shall be notified in writing of the State fair hearing decision and any appeal rights as provided by State and Federal law.

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

(1) The State fair hearing shall take final administrative action within 90 days of the earlier of:

(i) the date the Aggrieved Party 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 Aggrieved Party 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.

(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 as listed in Article 9.

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

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

(D) The Contractor and the Department shall ensure Enrollees are free to exercise their rights,

and that the exercise of those rights shall not adversely affect the way the Contractor and its Network Providers treat Enrollees.

9.1.2 Specific Enrollee Rights and Protections

(A) The Contractor shall include all of the following Enrollee rights and protections in its Enrollee handbook, and in any other written Patient Rights statement:

(1) the right to receive information about Contractor's PMHP;

(2) the right to be treated with respect and with due consideration for his or her dignity and privacy;
(3) the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

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

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

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

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

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

9.2 Network Provider-Enrollee Communications

9.2.1 General Requirements

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

(1) the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
(2) any information the Enrollee needs in order to decide among all relevant treatment options;

(3) the risks, benefits, and consequences of treatment or non-treatment; and

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

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 Generally

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

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

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

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

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

9.4 Advance Directives

9.4.1 Generally

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

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

(D) The Contractor shall educate staff concerning its policies and procedures on Advance Directives.

Article 10 – Contractor Assurances

10.1 General Assurances

10.1.1 Nondiscrimination

(A) The Contractor shall designate a nondiscrimination coordinator who shall:

(1) ensure the Contractor complies with Federal Laws and Regulations regarding nondiscrimination; and

(2) take Grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, sex, sexual orientation, gender identity, disability, or age.

(B) The nondiscrimination coordinator may also handle Grievances regarding the violation of other civil rights as other Federal laws and regulations protect against these forms of discrimination.

(C) The Contractor shall develop and implement a written method of administration to assure that the Contractor's programs, activities, services and benefits are equally available to all persons without regard to race, color, national origin, sex, sexual orientation, gender identity, disability, or age.

10.1.2 Member Services Function

(A) The Contactor shall operate a Member Services function during 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; and

(2) fielding and responding to Enrollee questions including questions regarding Grievances and Appeals.

10.1.3 Provider Services Function

(A) The Contractor shall operate 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 Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;

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

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

(4) assisting Providers with claims payment procedures, including training Providers on how to bill using the National Provider Identification Number or the Department-assigned atypical provider identification number that is known to Medicaid to avoid rejection of Encounters; and

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

10.1.4 Enrollee Liability

(A) The Contractor shall not hold an Enrollee liable for the following:

(1) The debts of the Contractor if it should become insolvent.

(2) Covered Services provided to the Enrollee, for which:

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

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

(3) The payments to Providers that furnish Covered Services under a contract or other agreement with the Contractor that are in excess of the amount that normally would be paid by the Enrollee if service had been received directly from the Contractor.

10.2 Contractor Assurances Regarding Access

10.2.1 Documentation Requirements

(A) The Contractor shall provide the Department adequate assurances and supporting documentation that demonstrates the Contractor has the capacity to serve the expected enrollment in its Service Area with the Department's standards for access to care.

(B) The Contractor shall provide the Department documentation, in a format specified by the Department, that the Contractor offers an appropriate range of mental health services that is adequate for the anticipated number of Enrollees for the Service Area, maintains a network of Network Providers that is sufficient in number, mix and geographic distribution to meet the

anticipated number of Enrollees in the Service Area.

(C) The Contractor shall submit to the Department the documentation assuring adequate capacity and services in the Department specified format no less frequently than:

(1) at the time it enters into a contract with the Department;

(2) at any time there has been a significant change (as defined by the Department) in the Contractor's operations that would affect adequate capacity and services including changes in services, benefits, geographic Service Area or payments, or enrollment of a new population in the Health Plan.

10.2.2 Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers and Physical Disability

(A) The Contractor shall minimize, with a goal to eliminate, the Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities.

(B) The Contractor shall provide assistance to Enrollees who have communications impediments or impairments to facilitate proper diagnosis and treatment.

(C) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TDD/TTY), and other auxiliary aids to all Enrollees as needed.

(D) The Contractor shall accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990, as amended.

(E) If the Contractor's facilities are not accessible to Enrollees with physical disabilities, the Contractor shall provide services in other accessible locations.

10.2.3 Interpretive Services

(A) The Contractor shall provide oral interpretive services available free of charge for all non-English languages, not just those the Department identifies as prevalent, on an as-needed basis. These requirements shall extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the Contractor and the Contractor's Network Providers and receive Covered Services.

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

(C) The Contractor shall ensure that its Network Providers have interpretative services available.

(D) Nothing in this Article 10.2.3 shall be construed to relieve Providers of their obligations to provide interpretive services under federal law.

(E) The Contractor shall cover interpretive services as described in the October 2013 Utah Medicaid Provider Manual and Medicaid Information Bulletin.

10.2.4 Cultural Competence Requirements

(A) The Contractor shall ensure the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that Enrollees have access to Covered Services that are delivered in a manner that meet their unique needs.

(B) The Contractor shall develop and implement a written cultural competency plan that encourages delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The written cultural competency plan shall address the following areas:

(1) overall systems issues, including the establishment of a cultural competency committee to promote cultural competency,

(2) human resource development including staff recruitment and retention and Provider training; and

(3) clinical issues, including treatment planning and delivery, and linguistic support.

(C)The Contractor shall maintain documentation of activities conducted in accordance with the plan and submit the written plan and/or documentation of the activities to the Department upon request.

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.

10.3 Coordination and Continuity of Care

10.3.1 In General

(A) The Contractor shall implement procedures to deliver care and to coordinate Covered Services for all Enrollees. These procedures must do the following:

(1) Ensure that each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity;

(2) Coordinate the services the Contractor furnishes to the Enrollee:

(i) between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

(ii) with the services the Enrollee receives from any other MCO, PIHP or PAHP,

(iii) with the services the Enrollee receives in FFS Medicaid; and

(iv) with the services the Enrollee receives from community and social support workers.

(B) The Contractor shall make a best effort to conduct an initial screening of each Enrollee's needs within 90 days of the effective date of enrollment for all new Enrollees and shall make subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful.

(C) The Contractor shall share with the Department or other MCOs, PIHPs, and PAHPs serving the Enrollee the results of any identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(D) The Contractor shall ensure that each Provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards.

(E) The Contractor shall ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable.

(F) The Contractor's Participating Providers are not responsible for rendering Home and Community-Based Waiver Services.

10.3.2 Accountable Care Organization

(A) When an Enrollee is also enrolled in an Accountable Care Organization (ACO), the Contractor and the ACO shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

(B) The Contractor shall educate its Network Providers regarding an effective model of

coordination between physical and mental health care services. The Contractor shall ensure its Network Providers coordinate the provision of physical health care services with mental health care services as appropriate.

(C) When an Enrollee is also enrolled in an ACO, the Contractor shall not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered.

10.3.3 Special Rules for Enrollees with Special Health Care Needs

(A) The Department shall identify Enrollees with Special Health Care Needs. The Contractor shall have a mechanism in place to ensure that Enrolees with Special Health Care needs may have direct access to a specialist.

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

(C)The Contractor shall notify the Department of any Enrollees it identifies who need LTSS services. The Contractor shall coordinate with the Department to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

10.4 Performance Standards for Timely Access

10.4.1 Definitions

For purposes of this Article 10.4, the following definitions apply:

> **Initial Contact** means an initial request to the Contractor for services by an Enrollee, the Enrollee's parent, legal guardian, or other representative, agency or provider that is made during normal business hours and includes Enrollees who are in the community, but not a hospital, at the time the contact is made. Initial Contacts may be made by telephone or in person. Contacts by an Enrollee, the Enrollee's parent, legal guardian, or other representative or agency to generally discuss mental health services or a need for a referral are not Initial Contacts. Initial Contacts are only those contacts that include discussion of an actual appointment for the first face-to-face service.
> **Non-Urgent Care** means Covered Services provided to an Enrollee when, based on the report of the Enrollee or his or her agent during the Initial Contac, symptoms are determined to be generally less intrusive and less serious to those requiring Urgent Care.
>
> **Urgent Care** means Covered Services provided to an Enrollee when the report of the Enrollee or his or her agent during the Initial Contact does not indicate dangerousness, but the Enrollee's functioning is seriously impaired and symptoms are moderate to severe.

10.4.2 Performance Standards, Generally

The Contractor shall adhere to the performance standards found in this Article 10.4 to ensure that Enrollees have timely access to first face-to-face services. The performance standards found in this Article 10.4 govern the timeframes from Initial Contact for offering first face-to-face services to Enrollees who are seeking Covered Services for the first time.

10.4.3 Initial Contacts

(A) The Contractor shall maintain an Initial Contact data system that allows for the Contractor to track and monitor adherence to performance standards for first face-to-face Covered Services when Enrollee Initial Contacts are made during the Contractor's regular business hours excluding Initial Contacts made to crisis services after hours and on weekends.

(B) When the Contractor shall provide the Covered Service directly or shall refer the Enrollee to a Subcontractor for the Covered Service, the Contractor shall document and maintain Initial Contact data for the Enrollee regardless of initial referral source and the performance standards found in this Article 10.4 apply.

(C) When an Enrollee seeks Covered Services directly from a Non-Network Provider or Subcontractor of his or her choosing, and the Contractor authorizes the request, the Contractor is not required to document Initial Contact data, and the performance standards found in this Article 10.4 do not apply.

10.4.4 Performance Standards

(A) If based on the Initial Contact it appears the Enrollee requires Emergency Services, the Contractor shall conduct a clinical screening by telephone within 30 minutes. If the Contractor determines that the Enrollee has an emergency, the contractor shall offer an outpatient face-to-face Emergency Service within one hour of completion of the telephone clinical screening, as appropriate. If an Initial Contact requiring outpatient Emergency Services is made on a walk-in basis, the Contractor shall offer a face-to-face outpatient Emergency Service within one hour.

(B) If it is determined during the Initial Contact that the Enrollee requires Urgent Care, the Contractor shall offer a face-to-face Covered Service within a maximum of five working days of Initial Contact. The Contractor shall also provide appropriate information regarding Emergency Services to the Enrollee with instructions to contact the contractor if more immediate services are needed.

(C) If it is determined during the Initial Contact that the Enrollee requires Non-Urgent Care, the Contractor shall offer a face-to-face Covered Service within 15 working days of the Initial Contact.

10.4.5 Documentation Requirements

(A) The Contractor shall document:

(1) The date and time of all Initial Contacts;

(2) Whether the Initial Contacts requiring Emergency Services are by telephone or on a walk-in basis;

(i) the date and time of 30-minute follow-up clinical screenings for emergencies;

(ii) the date and time of the emergent initial face-to-face appointment offered (if applicable); and

(iii) the date and time of the Urgent and Non-Urgent initial appointment offerings;

(3) Whether the Contractor is able to offer a first face-to-face service within the required timeframe and, if not, the reason;

(i) if the Contractor cannot offer the first face-to-face service within the required timeframe, this constitutes and Action if the Enrollee is not satisfied with waiting beyond the required timeframe. If applicable, the Contractor shall send the Enrollee a Notice of Action at the time it is determined that the Contractor cannot offer an appointment within the performance standards;

(4) The status of scheduled first face-to-face appointments: if they are kept, broken, cancelled and/or rescheduled by the Enrollee, or rescinded and rescheduled by the Contractor due to Contractor limitations and the date of any rescheduled appointments.

(i) If the Contractor must rescind and reschedule a previously offered and scheduled appointment for the first face-to-face service, and as a result will exceed the required timeframe, this constitutes an Action if the Enrollee is not satisfied with waiting beyond the required timeframe.

(ii) If applicable, the Contractor shall send the Enrollee a Notice of Action at the time it is determined the Contractor cannot meet the performance standard.

(B) The Contractor shall maintain documentation of the performance and report performance when requested by the Department using the Department's report template.

10.5 Billing Enrollees

10.5.1 Enrollee Billing, Generally

(A) Except as otherwise provided for in this Contract, no claim for payment shall be made at any time by the Contractor or its Network Providers to an Enrollee accepted by that Network Provider as an Enrollee for any Covered Service.

(B) When a Provider accepts an Enrollee as a patient he or she shall look solely to the Contractor and any third party coverage for reimbursement. If the Provider fails to receive payment from the Contractor, the Enrollee cannot be held responsible for these payments.

10.5.2 Circumstances in Which an Enrollee May Be Billed

(A) A Provider may bill an Enrollee for non-Covered Services only as outlined in this Contract.

(B) A non-Covered Service is a service that is not covered under this Contract, or is not authorized by the Contractor.

(C) The Department shall specify to the Contractor the extent of Covered Service and items under the Contract as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis.

(D) An Enrollee may be billed for a non-Covered Service when all of the following conditions are met:

(1) The Provider has an established policy for billing all patients for services not covered by a third party (i.e., the charge cannot be billed only to Enrollees);

(2) The Provider has informed the Enrollee of its policy for billing patients for non-covered services;

(3) The Provider has advised the Enrollee prior to rendering the non-covered service that the Enrollee shall be responsible for making payment; and

(4) An agreement, in writing, is made between the Provider and the Enrollee that details the service and the amount to be paid by the Enrollee.

(E) The Provider may bill the Enrollee for disputed services continued during the Appeal process if the if the requirements of Article 8.4.9(B) of this Contract and 42 CFR 431.230(b) are met.

10.5.3 Criminal Penalties

Criminal penalties shall be imposed on Providers as authorized under Section 1128B(d)(1) of the Social Security Act if the Provider knowingly and willfully charges an Enrollee at a rate other than those allowed under this Contract.

10.6 CHEC Requirements

10.6.1 General CHEC Requirements

(A) The Contractor shall provide mental health services available to CHEC Enrollees pursuant to 42 USC 1396d(r).

(B) The Contractor shall provide to CHEC Enrollees Medically Necessary Covered Services and all other services required under 42 USC 1396d(r).

(C) The Contractor shall have a process in place through which CHEC Enrollees may request the services as described in Article 10.6.1(A) and (B).

Article 11 Payments

11.1 General Payment Provisions

11.1.1 Risk Contract

This Contract is a Risk Contract.

11.1.2 Payment Methodology

The payment methodology is described in Attachment F of this Contract.

11.1.3 Contract Maximum

In no event shall the aggregate amount of payments to the Contractor exceed the Contract maximum amount. If payments to the Contractor approach or exceed the Contract amount before the renewal date of the Contract, the Department shall make a good faith effort to execute a Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

11.1.4 Payment Recoupment

(A) The Department shall recoup any payment paid to the Contractor which was paid in error. Such error may include human or mechanical error on either part of the Contractor or the Department. Errors can include, but are not limited to, lack of eligibilit or computer error.

(B) If the Contractor disagrees with the Department's determination that an payment was made in error, the Contractor may request an administrative hearing within 30 days of the Department's recoupment of the overpayment.

11.1.5 Overpayments

(A) The Contractor shall specify:

(1) the retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse.

(2) The Contractor shall specify the process, timeframes, and documentation required for reporting the recovery of all Overpayments.

(3) The Contractor shall specify the process, timeframes, and documentation required for payment of recoveries of Overpayments to the Department in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

(B) The Contractor shall have and use a mechanism for a Network Provider to report to the Contractor when it has received an Overpayment, to return the Overpayment to the Contractor within 60 calendar days after the date on which the Overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.

(C) The Contractor shall submit to the Department an annual report of Overpayment recoveries. The report shall be in a Department specified format.

11.2 Third Party Liability and Coordination of Benefits

11.2.1 Recovery of Third Party Liability, Generally

The Contractor shall make reasonable efforts to pursue the recovery of Third Party Liability for Services provided to Enrollees. Third Party Liability may include, but is not limited to private health insurance, automobile insurance, Medicare, Tricare or an employer-administered ERISA plan.

11.2.2 Policies and Procedures for Third Party Liability Recovery

(A) The Contractor shall develop policies and procedures describing how it intends to conduct Third Party Liability recovery. Such policies and procedures shall be consistent with the requirements of
42 U.S.C. 1396(A)(25) and 42 CFR 433 Subpart D. The policies and procedures shall contain:

(1) Procedures and Mechanisms to identify potentially liable Third Parties;
(2) Procedures and Mechanisms to identify the amount owed by a Third Party; and

(3) Procedures and Mechanisms for recovery of Third Party Liability payments.

11.2.3 Pay and Chase and Cost Avoidance

(A) Contractor will use reasonable efforts to evaluate the probable existence of Third Party Liability and may not shift that burden to a Provider. Probable existence of Third Party Liability exists where:

(1) the Contractor has confirmed that there was Third Party Liability in effect on the Enrollee's date of service; and

(2) the Contractor has determined that the Third Party Liability will likely cover the service received by the Enrollee.

(B) Except as otherwise provided in Article 11.2.3(C) of this Contract, when the Contractor is aware of the probable existence of Third Party Liability at the time a claim from a Provider is filed with the Contractor:

(1) The Contractor must reject the claim and return it to the Provider for a determination of the amount of liability.

(2) The establishment of Third Party Liability takes place when the Contractor receives confirmation from the Provider or a third party resource indicating the extent of third party liability. If the Provider or the third party gives reasonable evidence that the Third Party Liability was not in effect at the time of service or the service received by the Enrollee is not covered by the Third Party Liability the Contractor shall pay the claim, to the extent that the service is a Covered Service.

(3) When the amount of liability is determined, the Contractor must then pay the claim to the extent that payment allowed under the Contractor's payment schedule exceeds the amount of the third party's payment.

(C) In the following situations, the Contractor must pay the Provider's claim first and then seek reimbursement from the liable third party:

(1) the claim is prenatal care for women, or preventative pediatric services (including early and periodic screening, diagnosis and treatment services provided for under 42 CFR 441, Part B), and is covered under the State Plan;

(2) the claim is for a service covered under the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. In this instance the Contractor must pay the Provider if, after 30 days, it has not received payment from the third party carrier.

(D) If the probable existence of Third Party Liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the Contractor must pay the claim pursuant to the Contractor's payment schedule. When the Contractor determines that Third Party Liability exists, the Contractor must seek reimbursement from the third party within 60 days of discovery of the Third Party Liability.

(E) Recovery is not required when claim is $100 or less for health insurance or $300 or less for cumulative claims.

(F) Contractor shall retain any payment it receives stemming from Third Party Liability. The Contractor shall report any Third Party Liability Recoveries on the 837 File.

11.2.4 Third Party Liability and Access to Care

(A) The Contractor cannot require an Enrollee to obtain Covered Services from Providers that accept the Enrollee's Third Party Liability.

(B) The Contractor shall pay Claims for Covered Services obtained by an Enrollee from a Network Provider even if the Network Provider does not accept the Enrollee's Third Party Liability.

(C) The Contractor shall pay Claims for Covered Services from a Non-Network Provider in the

event that the Contractor has required the Enrollee to obtain Covered Services from the Non-Network Provider for the purposes of utilizing the Enrollee's Third Party Liability.

11.2.5 Medical Support Orders

The Contractor shall notify the Office of Recovery Services if the Contractor discovers that an Enrollee's parent has a duty to provide medical support.

11.3 Contractor's Payment Responsibilities

11.3.1 Covered Services Received Outside Contractor's Network but Paid by the Contractor

(A) The Contractor shall not be required to pay for Covered Services when the Enrollee receives the services from sources outside the Contractor's network, not arranged for and not authorized by the Contractor except as follows:

(1) Emergency Services;

(2) Court ordered services that are Covered Services defined in Attachment C; or
(3) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the Contractor's Network Providers.

11.3.2 Payment to Non-Network Providers

(A) Payment by the Contractor to a Non-Network Provider for Emergency Services for services that are approved for payment by the Contractor shall not exceed the lower of the following rates applicable at the time the services were rendered to an Enrollee, unless there is a negotiated arrangement:

(1) The usual charges made to the general public by the Provider;

(2) The rate equal to the applicable Medicaid fee-for-service rate; or

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

11.3.3 Covered Services which are Not the Contractor's Responsibility

(A) The Contractor shall not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to earthquakes or acts of war. The effective date of excluding such Covered Services shall be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

(B) An Enrollee who is Indian may choose to seek Covered Services from an Indian Health Care Provider. The Contractor shall not be required to pay for Covered Services provided to Indian

Enrollees who receive services provided by Indian Health Care Providers. Such services shall be paid by the Department.

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

11.4.1 Plan Transitions, Inpatient Hospital Stays

(A) When an Enrollee is in an inpatient hospital setting and becomes Fee-For-Service any time prior to discharge from the hospital, the Contractor is financially responsible for the entire hospital stay including all services related to the hospital stay until discharged.

(B) If a Medicaid Eligible Individual is Fee-For-Service when admitted to the hospital and is enrolled in the Contractor's PMHP at any time prior to discharge from the hospital, the Department is financially responsible for the entire hospital stay including all services related to the Hospital stay until discharged.

Article 12 Additional Recordkeeping and Reporting Requirements

12.1 Recordkeeping Requirements

12.1.1 Health Information Systems, General Requirements

(A) The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including but not limited to, utilization, Claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

(B) The Contractor shall comply with Section 6504(a) of the Affordable Care Act which requires the Department claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meeting Section 1903(r)(1)(F) of the Social Security Act.

(C) The Contractor shall collect data on Enrollee and Provider characteristics as specified by the Department, and on all services furnished to Enrollees through an Encounter Data system or other methods as may be specified by the Department.

12.1.2 Accuracy of Data

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

(1) verifying the accuracy and timeliness of the reported data, including data from Network Providers the Contractor is compensating on the basis of subcapitation payments;

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

(3) collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts.

(B) The Contractor shall make all collected data available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law.

12.1.3 Medical Records

(A) The Contractor shall maintain a medical record keeping system that complies with state and federal law.

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

12.1.4 Document Retention Requirements for Awards

(A) The Contractor shall comply with the record retention and record access requirements for award recipients found in 45 CFR 74.53 which requires the Contractor to maintain financial records, supporting documents, statistical records, and all other records pertaining to an award to be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annual, from the date of the submission of the quarterly or annual financial report. The three year retention requirement does not apply:

(1) If any litigation, claim, financial management review or audit is started before the expiration of the 3 year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action apply;

(2) To records for real property and equipment acquired with Federal funds which shall be retained for 3 years after final disposition;

(3) When records are transferred to or maintained by the HHS awarding agency, the 3 year retention is not applicable to the recipient; and

(4) To indirect cost rate computations or proposals, cost allocation plans and any similar computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates.

12.1.5 Record Retention Requirements

(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, Contractor's policies and procedures, Contractor's

Enrollee handbooks, and copies of reports required by the Department.

(B) The Contractor shall retain, and shall require its Subcontractors to retain Enrollee Grievance and Appeal records, base data, MLR reports, and the data, information and documentation specified in 42 CFR sections 468.604, 438.606, 438.608, 438.610 for a period of no less than 10 years.

12.2 Additional Reporting Requirements

12.2.1 Independent Financial Audit(s)

(A) The Contractor shall submit an audited financial report to the Department by October 31st of each year. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

(B) The Contractor shall notify the Department of the dates of the entrance and exit conferences with the independent CPA firm conducting annual independent financial audits with the Contractor and shall allow the Department to participate in those conferences.

(C) The Contractor shall electronically submit to the Department a copy of the final annual independent financial audit that is conducted to satisfy the financial audit requirement for the Local Authority. The Contractor shall submit a final copy of the report to the Department.

12.2.2 Enrollment, Cost and Utilization Reports

(A) The Contract 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 Department may amend the report at its discretion.

(B) The Contractor shall certify, in writing, the accuracy and completeness, to the best of its knowledge, of all the annual PMHP Financial Report.
(C) The Contractor shall ensure that the report is completed according to the Department's instructions.

(D) The Contractor shall submit this report by October 31st of each year. If the Department does not receive the report by October 31st, or if the report is not correctly completed per the Department's Instructions, the Department may suspend the Contractor's Capitation Payments until the report is received or correctly completed.

12.2.3 Semi-Annual Reports

(A) The following semi-annual reports are due January 31 for the preceding six month reporting period ending December 31 (July through December) and are due July 31 for the preceding six month period ending June 30 (January through June):

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

12.2.4 Provider Network Reports

The Contractor shall submit a report to the Department, in a format specified by the Department, to demonstrate that the Contractor offers an appropriate range of Covered Services that is adequate for the anticipated number of Enrollees in the Service Area and that the Contractor maintains a network of Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area.

12.2.5 Data Collection

(A) By July 1st of each year, the Contractor shall provide the following information to the Department, in a Department specified format:

(1) enrollment and disenrollment data;

(2) Enrollee Grievance and Appeal logs;

(3) Provider complaint and Appeal logs;

(4) the results of any Enrollee or Provider satisfaction survey conducted by the Contractor;

(5) performance on required quality measures;

(6) medical management committee reports and minutes;

(7) the Contractor's annual quality improvement plan;

(8) audited financial and Encounter Data;

(9) the MLR summary reports; and

(10) customer service performance data.

12.2.6 Development of New Reports

The Department may request other reports deemed necessary to the Department to assess areas including, but not limited to, access and timeliness or quality of care. The Contractor agrees to submit any report requested by the Department within the time frames specified by the Department.

12.3 Encounter Data

12.3.1 Encounter Data, General Requirements

(A) In accordance with Section 1903(m)(2)(A)(xi) of the Social Security Act, the Contractor agrees to maintain sufficient patient Encounter Data to identify the Provider who delivers Covered Services to Enrollees.

(B) The Contractor shall transmit data to the Department using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR 162.1101 and 162.1102.

(C) The Contractor shall transmit and submit all Encounter 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 a quarter. The Encounter Data shall represent all Encounter Claim types (medical and institutional) received and adjudicated by the Contractor the previous quarter. The Department may suspend the Contractor's Capitation Payment if the Contractor's Encounter Data is not received on a quarterly basis.

(E) The Department will edit Encounter Data in accordance with HIPAA standards and Department instructions. 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 the Contractor a 999 Implementation Acknowledgement for Health Care Insurance or a TA1 Interchange acknowledgment regarding file acceptance. The Department shall the Contractor a 277 Health Care Claim Status Response Transaction to the Contractor advising the Contractor of the status of the processed claims. The Contractor shall be responsible for reviewing the 999, TA1, and 277 transactions and taking appropriate action when necessary.

(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.

(H) The Contractor shall submit Encounter Data for all services rendered to Medicaid Enrollees under this Contract, including Encounters where the Contractor determined no liability exists. The Contractor shall submit Encounter Data even if the Contractor did not make any payment for a Claim, including Claims for services to Medicaid enrollees provided under a Subcontract, capitation or special arrangement with another facility or program. The Contractor shall submit Encounter Data for all services provided under this Contract to Medicaid Enrollees who also have Medicare coverage.

(I) If the Contractor discovers that services and/or costs of Excluded Providers have been included in the Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter Data.

12.3.3 Excluded Encounters

(A) The Contractor shall not submit Encounter Data:

(1) where another PMHP has received a Capitation Payment and paid the Contractor for the service; or

(2) for services performed by the Contractor but the client is enrolled in the HOME program.

12.4 Disallowance of Claims

12.4.1 Procedures for Incorrectly Paid Claims

(A) The Contractor shall take reasonable action to collect any incorrectly paid claim from the Provider within 12 months of the date of discovery of the incorrectly paid claim. Incorrectly paid claims can include but are not limited to claims which were duplicative, overpaid, or disallowed.

(B) The Contractor shall reverse the Encounter(s) for the incorrectly paid claims within sixty (60) days of the earlier of (1) the date of discovery of an incorrectly paid claim or (2) the date of the notice of the disallowance of the incorrectly paid claim. The Contractor shall correct any Encounter(s) for any incorrectly paid claim regardless of whether the Contractor is successful in collecting the payment from the Provider.

(C) The Contractor shall make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

(1) the Provider has submitted a Claim for the date of service within 12 months of the date of service;

(2) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had a primary insurance that should have paid on the Claim;

(3) the Provider can show, through EOBs or other sufficient evidence that the primary insurance was either not in effect or will not cover the billed service; and

(4) absent the coordination of benefits issues or the timely filing issues, the Claim is otherwise payable.

12.5 Medical Loss Ratio

12.5.1 Medical Loss Ratio, Generally

(A) The Contractor shall calculate and report to the Department a MLR for each State Fiscal Year, consistent with the MLR standards described in this Article 12.5. The MLR report shall be

submitted to the state by October 1st of each year.

(B) The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract unless the Department requires separate reporting and a separate MLR calculation for specific populations.

12.5.2 Medical Loss Ratio, Calculations

(A) The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(d)-(f).

(B) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(C) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

(D) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(E) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(F) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

12.5.3 Medical Loss Ratio, Credibility Adjustment

(A) The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

(B) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department.

(C) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(D) If the Contractor’s experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

2.5.4 Medical Loss Ratio, Reporting

(A) The Contractor shall submit a MLR report to the Department that includes, for each MLR reporting year: total incurred claims, expenditures on quality improving activities, expenditures related to activities compliant with program integrity requirements, non-claims costs, premium revenue, taxes, licensing fees, regulatory fees, methodology(ies) for allocation of expenditures, any credibility adjustment applied, the calculated MLR, any remittance owed to the Department (if applicable), a comparison of the information reported with the audited financial report, a description of the aggregation method used to calculate total incurred claims, and the number of member months.

(B) The Contractor shall submit the MLR report in a Department specified format no later than October 31st of each year. The Contractor's first MLR report shall be due on October 31, 2018.

(C) The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(D) In any instance where the Department makes a retroactive change to the Capitation Payments for a MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and submit a new MLR report meeting the applicable requirements.

(E) The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

12.6 Data Submission and Certification

12.6.1 Data Submission

(A) The Contractor shall submit the following data to the Department which is subject to the certification requirements found in 12.6.2:

(1) Encounter Data in the form and manner described in 42 CFR 438.818 and this Contract;

(2) data on the basis of which the Department certifies the actuarial soundness of Capitation Rates to the Contractor under 42 CFR 438.4, including base data described in 42 CFR 438.5(c) that is generated by the Contractor;

(3) data on the basis of which the Department determines the compliance of the Contractor with the MLR requirement described in this Contract at 42 CFR 438.8;

(4) data on the basis of which the Department determines that the Contractor has made

adequate provision against the risk of insolvency as required under this Contract and 42 CFR 438.116;

(5) Documentation described in 42 CFR 438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR 438.206;

(6) Information on ownership and control described in this Contract, 42 CFR 455.104 and 42 CFR 438.230; and

(7) the annual report of Overpayment recoveries as required by 42 CFR 438.608(d)(3).

(B) The Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's obligations under 42 CFR Part 438 as required by the Department or the Secretary of Health and Human Services.

12.6.2 Data Certification

(A) The individual who submits data, documentation or information described in Article 12.6.1 to the Department shall provide a certification, concurrently with the submission, which attests, based on the individual's best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.

(B) The data, documentation, or information required by 12.6.1 shall be certified by:

(1) The Contractor's Chief Executive Officer (CEO);

(2) The Contractor's Chief Financial Officer (CFO); or

(3) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

Article 13 Compliance and Monitoring

13.1 Audits

13.1.1 Inspection and Audit of Financial Records

(A) The Department and the federal government may inspect and audit any books and/or records of the Contractor or its Network Providers that pertain to:

(1) the ability of the Contractor to bear the risk of potential financial losses, or

(2) to services performed or determinations of amounts payable under the Contract, or

(3) for any other audit allowed by state or federal law.

(B) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law any of the Contractor's records that may reasonably be requested to conduct the audit.

(C) The Contractor shall, in accordance with 45 CFR 74.48 (and except for contracts less than the simplified acquisition threshold), allow the HHS awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

13.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other client data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

13.1.3 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, Fraud-related data, Abuse-related data, patient outcome data, and cost utilization data, which shall include patient profiles, exception reports, etc.

(B) The Contractor shall provide all data required by the Department, the federal government, independent quality review examiners, and other Utah state agencies allowed to conduct such audits.

13.2 Utah Office of the Inspector General

13.2.1 General Requirements

(A) The Contractor shall cooperate with the Utah OIG in any performance or financial audit Medicaid funds received by the Contractor as allowed by Utah Code Ann. §63A-13-202(2).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. §63A-13-301.

(C) The Contractor and its employees shall cooperate with the Utah OIG with respect to an audit or investigation as required by Utah Code Ann. §§63A-13-302, 303.

(D) In accordance with Utah Code Ann. §63A-13-304, the Contractor and its employees shall not interfere with a Utah OIG audit or investigation.

(E) The Contractor shall comply with all subpoenas from the Utah OIG that are properly issued pursuant to Utah Code Ann. §63A-13-401.

(F) The Contractor shall allow the Utah OIG to conduct announced or unannounced site visits in accordance with 42 CFR 455.432.

Article 14 Corrective Action and Sanctions

14.1 Corrective Action Plans

14.1.1 Corrective Action Plans, Generally

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department may impose a corrective action plan to cure the Contractor's non-compliance.

(B) At the Department's discretion, the corrective action plan may be developed by the Department or the Contractor.

14.1.2 Department-Issued Corrective Action Plan

(A) The Department may develop a corrective action plan which the Department shall provide to the Contractor, in writing.

(B) The Contractor agrees to comply with the terms of a Department-issued corrective action plan and to complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan.

(C) If the Contractor disagrees with the Department's corrective action plan, the Contractor may file a request for an administrative hearing within 30 days of receipt of the Department's corrective action plan.

14.1.3 Contractor Generated Corrective Action Plan

(A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.

(B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.

(C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 days of receipt. In the event that the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised. The corrective action plan submitted by the Contractor shall be deemed approved by the Department if the Department fails to respond to the Contractor within 20 days of receipt of the Contractor's corrective action plan.

(D) The Contractor agrees to comply with the terms of a Department approved corrective action plan and to complete all required actions within the required timeframes.

14.1.4 Notice of Non-Compliance

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and time frame in which the Contractor's non-compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 days to cure its non-compliance. However, the Department may shorten the 30 day time period in the event that a delay would endanger an Enrollee's health or the timeframe must be shortened in order for the Department and the Contractor to meet federal guidelines.

(B) If the Contractor fails to cure the non-compliance as ordered by the Department and within the timeframes designated by the Department, the Department may, at its discretion, impose any or all of the following sanctions:

(1) Suspension of the Contractor's Capitation Payment;

(2) Assessment of Civil Monetary Penalties; and/or

(3) Imposition of any other sanction allowed by federal and state law.

(D) The Department's imposition of any of the sanctions described in 14.1.4(B) is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in 14.1.4(B) in no way limits additional remedies, at law or at equity, available to the

Department due to the Contractor's Breach of this Contract.

(E) The Department may impose any additional sanctions on the Contractor provided for under state statutes or regulations to address non-compliance.

14.2 Capitation Payment Suspension

14.2.1 Capitation Payment Suspension, Generally

(A) The Department may suspend Contractor's Capitation Payment in the event that the Contractor fails to comply with any provision of this Contract.

(B) The Department may suspend the Contractor's Capitation Payment for any failure to submit or comply with a corrective action plan within the timeframes required by the Department.

14.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 days.

(B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments, the Contractor may request an administrative 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 hearing officer to release the Capitation Payments.

Article 15 Termination of the Contract

15.1 Without Cause Termination

15.1.2 Termination Without Cause

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

be on the first working day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 days written notice.

15.1.3 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services and related administrative functions required by this Contract until midnight of the last calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or thirty days following termination, whichever occurs first.

(B) Upon any termination of this Contract the Contractor shall promptly supply to the Department any information it requests regarding paid and unpaid Claims.

(C) If the Contractor one of its Network Providers, or other subcontractor becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor, the Network Provider, or the Subcontractor.

15.2 Termination of Contract With Cause

15.2.1 Termination of Contract With Cause, Generally

(A) In accordance with 42 CFR 438.708, the Department may terminate this Contract and enroll the Contractor's Enrollees in other MCOs or PCCMs or provide their Medicaid benefits through other
options included in the State Plan, if the Department determines that the Contractor has failed to:

(1) Carry out the substantive terms of this Contract; or

(2) Meet the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act.

15.2.2 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

15.3 Close Out Provisions

15.3.1 Close Out Provisions

(A) Notwithstanding any provision found in Attachment A, in the event of termination of this

Contract, the Contractor shall complete any and all duties required by this Contract including, but not limited to the following:

(1) processing and paying any Claims generated during the lifetime of this Contract including completing appeals by both Providers and/or Enrollees and any monetary reconciliations;

(2) providing the Department with complete and accurate Encounter Data for all Encounters generated during the lifetime of this Contract;

(3) providing the Department with reports as required by this Contract;

(4) complying with any audit requests.

(B) Failure of the Contractor to comply with the provisions found in this Article 15.3 shall be deemed a breach of Contract and the Department may exercise any remedy available under this Contract or by operation of law. The Department shall give the Contractor notice of any activities not completed after termination and shall give the Contractor an opportunity to cure any breaches prior to declaring a breach of the Contract.

Article 16 Miscellaneous Provisions

16.1 Additional Provisions

16.1.1 Integration

This Contract and all attachments hereto, contain the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.

16.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

16.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

16.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

16.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

16.1.6 Continuation of Services During Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly Capitation Payments to the Contractor.

16.1.7 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's policies and procedures in Provider Manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its Network Providers comply with the policies and procedures in effect at the time when services are rendered.

(B) The Contractor shall comply with all appropriate and applicable state and federal rules and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

16.1.8 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

16.1.9 CMS Approval of Contract

The Contractor understands and agrees that this Contract is subject to approval by CMS. The Contractor agrees to execute any amendment necessary to make this Contract compliant with any CMS requirements. The Contractor shall be responsible for repayment of any disallowances of Federal Financial Participation in the event the Contractor refuses to execute a contract amendment to bring the Contract into compliance with any CMS requirements.

16.3 Data Security Provisions

16.2.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

16.2.2 Network Security

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

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to one of the following:

(1) Those standards which the State of Utah applies to its own network as found at http://www.dts.utah.gov;

(2) Current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) Any industry accepted standards that is comparable to those described in 16.2.2(B)(1) or (2).

16.2.3 Data Security

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

(1) Standards that are at least as good as or better than that maintained by the State of Utah found at http://www.dts.utah.gov;

(2) Current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) Any industry accepted standards that is comparable to those described in 16.2.3(A)(1) or (2).

(B) The Contractor shall develop and use appropriate administrative, technical and physical security measures to preserve the confidentiality and integrity of all electronically maintained or

transmitted Confidential Data. These security measures include, but are not limited to, maintaining up-to-date anti-virus software, maintaining systems with current security updates, and controlled access to the physical location of the hardware itself.

16.2.4 Data Transmission

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

16.2.5 Data Storage

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

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

16.2.6 Data Re-Use

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

16.2.7 Notification of Confidential Data Breach

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

16.2.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the Duty of Confidentiality found in Article 16.2.1 and the Confidential Data requirements found in Articles 16.2.2 through 16.2.7 to all Subcontractors used by the Contractor.

16.2.9 Access to State of Utah Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to

any database maintained by the State of Utah or by the Department to whom the Department has given access.

(B) The Contractor shall notify the Department within two business days when an employee or subcontractor who has access to a database maintained by the Department or the State no longer requires access to the database.

(C) On a quarterly basis the Contractor shall provide to the Department a log of all employees who have access to a Department or State maintained database and in submitting that log to the Department, shall certify that the job duties of each employee named in the log requires that employee to have access to a Department-maintained database.

Attachment C – Covered Services

Article 1: Covered Services, Limitations, & Exclusions

1.1 Covered Services

1.1.1 Covered Services, Generally

(A) The Contractor shall provide all services listed under this Article 1.1 as a Covered Services.

(B) The Parties agree that State Plan, the State's 1915(b) Waiver, and the Department's Provider Manuals are the official listings of the specific services and codes Medicaid covers pursuant to the Medicaid State Plan. In the event of a conflict between the State Plan, the 1915(b) and the Department's Provider Manuals the Department retains the right to determine whether the codes are Covered Services under this Contract and the State Plan.

(C) The Contractor shall administer Covered Services in accordance with the Medicaid Provider Manuals. Medicaid Provider Manuals provide detailed information regarding Covered Services and are available to the Contractor on the Department's website.

(D) The Department shall have the right to interpret the State Plan, Provider Manuals, Medicaid Information Bulletins and the Coverage and Reimbursement Code Look Up Tool.

(E) The Contractor agrees that any Covered Services can only be limited through utilization criteria based on Medical Necessity.

(1) (F) The Contractor shall ensure that Medically Necessary Covered Services are 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. Those records will be made available to the Department upon request.

1.1.2 Outpatient Substance Use Disorder Services

(A) The outpatient services listed in this Article 1.1.2(B) are Covered Services for Traditional and Non-Traditional Medicaid Enrollees.

(B) The following are a list of outpatient services which are Covered Services under this Contract:

(1) Psychiatric diagnostic interview examination;

(2) Mental health assessment by a non-mental health therapist;

(3) Psychological Testing;

(4) Individual psychotherapy;

(5) Group psychotherapy;

(6) Individual therapeutic behavioral services;

(7) Group therapeutic behavioral services;

(8) Individual psychotherapy with medical evaluation and management services;

(9) Family psychotherapy with Enrollee present;

(10) Family psychotherapy without the Enrollee present;

(11) Pharmacologic management;

(12) Individual skills training and development services;

(13) Psychosocial rehabilitative services;

(14) Peer support services;

(15) Targeted Case Management Services;

(16) General medical consultations, neurological examinations, and neuropsychological testing which are Medically Necessary for diagnosing a substance use disorder; and

(17) Psychiatric services rendered by a psychiatrist in the emergency room to assess a substance use disorder.

(C) The Contractor is responsible for the payment of outpatient Covered Services regardless of whether the Enrollee has a co-occurring diagnosis of a mental health disorder, developmental disorder, intellectual disability, or organic disorder.

1.1.3 Substance Use Disorder Evaluations Ordered by Department of Workforce Services or the Department of Health

(A) Substance use disorder evaluations or reevaluations, which may include psychological testing, in order to meet federal Social Security Disability guidelines for determining disability, requested by Department of Workforce Services or the Department of Health to determine disability related to Medicaid eligibility are Covered Services if the individual is an Enrollee and a face-to-face visit is necessary to complete the Medicaid eligibility evaluation or reevaluation.

(B) Evaluations requested by a court or the Utah Department of Human services to determine if a Medicaid-eligible child or parent has a diagnosis of a substance use disorder and to recommend a course of treatment are Covered Services.

1.1.4 Special Rules for Coverage of Services for K Children

K Children are carved out of this Contract.

1.1.5 Special Rules for Enrollees in Nursing Facilities or Receiving Waiver Services

(A) The Contractor shall provide Covered Services to Enrollees in nursing facilities, including ICF/IDs and Enrollees in Home and Community Based Services waiver programs.

(B) The Contractor shall be responsible for coordinating treatment planning and service delivery with the nursing facility, ICF/ID or waiver organization to ensure timely delivery of Covered Services to the Enrollee.

1.1.6 CHEC Services

(A) The Contractor shall provide substance abuse disorder services available to CHEC Enrollees pursuant to 42 USC 1396d(r).

1.2 Carved out Services

1.2.1 Categories of Carved out Services

(A) The Contractor is not responsible to cover the following Medicaid State Plan or 1915(b) Waiver services. These services are carved out of this Contract:

(1) Inpatient hospital services for substance use disorders, including medical detoxification;

(2) Outpatient methadone maintenance treatment;

(3) Evaluations requested by a court or the Utah Department of Human Services, Division of Child and Family Services, solely for the purpose of determining if a parent is able to parent and should therefore be granted custody or visitation rights;

(4) Psychiatric services ordered by an Enrollee's physician while hospitalized in a non-psychiatric unit of a hospital;

(5) Outpatient Covered Services solely targeting the diagnosis or treatment an Enrollee's mental health disorder, developmental disorder, intellectual disability, or organic disorder.

(6) Substance use disorder evaluations, including psychological testing, prior to organ transplantations or other medical or surgical procedures.

Article 2: Co-Payments

2.1 Co-Payments, Generally

2.1.1 Allowed Co-payments

(A) The Contractor shall only charge Enrollee the co-payments allowed by the Department.

(B) The Contractor shall not charge a co-payment to Indian Enrollees, pregnant women, and Enrollees who qualify for CHEC.

(2) (C) The Contractor shall ensure that any cost sharing imposed on Enrollees is in accordance with 42 CFR 447.50 through 42 CFR 447.60.

Attachment D—Quality

1.1 Quality Assessment and Performance Improvement Program

1.1.1 Quality Assessment and Performance Improvement, Generally

(A) Pursuant to 42 CFR 438.330, the Contractor shall have an ongoing comprehensive Quality Assessment and Performance Improvement Program (QAPIP) for the services it furnishes to its Enrollees.

(B) The QAPIP shall include a policymaking body which oversees the QAPIP, a designated senior official responsible for administration of the program, an interdisciplinary QAPIP committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body, and other functional areas of the organization.

(C) The Contractor agrees that CMS, in consultation with States and other stakeholders, may specify performance measures and topics for Performance Improvement Projects (PIPs) that would be required for the Contractor to implement.

1.1.2 Basic Elements of Quality Assessment and Performance Improvement Programs

(A) At minimum, the Contractor shall establish and maintain a QAPIP that complies with the following requirements:

(1) Conduct Performance Improvement Projects (PIPs) in accordance with Article 1.1.4;

(2) Collect and submit performance measurement data in accordance with Articles 1.1.5;

(3) Have in effect mechanisms to detect both underutilization and overutilization of services; and

(4) Have in effect mechanisms (e.g. peer reviews as specified in Article 1.1.5) to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs.

1.1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Articles 1.1.1 and 1.1.2.

(B) The Contractor shall submit its written QAPIP plan to the Department by August 31st of each year.

1.1.4 Performance Improvement Projects

(A) The Contractor shall conduct ongoing Performance Improvement Projects (PIPs) that focus

on clinical or nonclinical areas, including any PIPs required by CMS or the Department.

(B) Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and that include the following:

(1) Measurement of performance using objective quality indicators;

(2) Implementation of interventions to achieve improvement in the access to and the quality of care;

(3) Evaluation of effectiveness of the interventions based on the quality indicators in Article 1.1.4(B)(1); and

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

(B) Before implementing a new PIP, the Contractor shall submit the topic to the Department for approval using a format specified by the Department.

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

(D) The Contractor agrees that the Department may, at its discretion, set up a timeframe and deadline for the Contractor to complete a PIP.

1.1.5 Performance Measurement

(A) Annually, the Contractor shall:

(1) Measure and report to the Department its performance, using standard measures required by the Department and/or CMS;

(2) Submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or

(3) Perform a combination of the above activities.

(B) The Contractor shall compile and submit its performance measures report for the preceding calendar year as specified by the Department.

1.1.6 Peer Review

(A) The Contractor shall develop and implement written policies and procedures that describe in detail the Contractor's peer review program.

(B) The Contractor's peer review procedures shall address frequency, methodology, documentation of reviews, and the process for making improvement recommendations when applicable.

1.2 Quality Tracking and Monitoring

1.2.1 Quality Measures

(A) The Contractor shall report to the Department the quality measures specified in Article 1.2.4 by August 1st of each year.

(B) The Contractor agrees that the Department may amend the quality measures found in Article 1.2.4. The Department, when possible, shall consult with the Contractor prior to changing the reportable quality measures, and when possible, shall negotiate with the Contractor the effective date of any new quality measures.

(C) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

1.2.2 Quality Measure Targets

(A) The Contractor shall establish a targeted rate for each year of a five-year period for each quality measure listed in Article 1.2.4. The Contractor agrees that the five-year period shall be established by the Department.

(1) The Contractor's baseline rate and the national average rate for each quality measure shall be based on performance in the calendar year prior to the five-year period.

(2) For each quality measure, the Contractor's targeted rates shall adhere to the following:

(i) If the Contractor's baseline rate is below the national average rate, the targeted rate for year-five shall be at or above the national average rate as specified in Article 1.2.2(A)(1);

(ii) If the Contractor's baseline rate is at or above the national average rate, the targeted rate for year-five shall be at or above the baseline rate as specified in Article 1.2.2(A)(1).

(3) The Contractor agrees that the Department shall approve the Contractor's targeted rates for each quality measure.

1.2.3 Quality Targeted Improvement Plan

(A) The Contractor shall develop and implement a written plan for each quality measure describing how it will achieve or maintain the targeted rates as specified in Article 1.2.2. The

written plan shall be in the Department-specified form called the Quality Targeted Improvement Plan (QTIP).

(C) The Contractor shall submit its QTIP on a date specified by the Department.

(D) The Contractor shall revise its QTIP (including targeted rates and implementation plan) upon request by the Department.

(E) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

1.2.4 Quality Measures Table

	Measure Name	**Responsible for Rate Calculation**
(A)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS-IET)	Contractor

1.2.5 Quality Measure Corrective Actions

(A) In the event that the Contractor's quality measure performance is not at or above the national average as required by this Article, the Contractor may be subject to the corrective actions found in Article 14 of Attachment B.

1.3 External Quality Review

1.3.1 External Quality Review, Generally

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

(B) The Contractor shall maintain, and make available to the External Quality Review Organization (EQRO), all clinical and administrative records for use in EQRs.

(C) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

1.3.2 Contractor Staffing Requirements

(A) The Contractor shall designate an individual to serve as a liaison for the EQRs.

(B) The Contractor shall designate representatives, as needed, including but not limited to a quality improvement representative and a data representative to assist with EQRs.

1.3.3 Copies and On-Site Access

(A) The Contractor shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during an on-site review.

(B) Document copying costs are the responsibility of the Contractor.

(C) Enrollee information includes, but is not limited to, medical records, administrative data, encounter data, and claims data, maintained by the Contractor or its Participating Providers.

(D) On-Site EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate work space, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

1.3.4 Timeframe for Providing Information

(A) The Contractor shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by the Department.

(B) The Contractor agrees that the Department shall review requests for extensions of these timeframes and that the Department shall approve or disapprove the request.

1.4 Miscellaneous Quality Provisions

1.4.1 Accrediting

(A) The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.

(B) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide the Department a copy of its most recent accreditation review including;

(1) Accreditation status, survey type, and level (as applicable);

(2) Accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings, and

(3) Expiration of the date of accreditation.

Attachment E - Payment Methodology

Article 1: Risk Based Contract

1.1 Contract Classification

(A) This Contract is classified as a Risk Contract and pursuant to 42 CFR 438.812(a) the total amount the Department pays for carrying out the contract is a medical assistance cost.

(B) The Contractor shall provide all services required by this Contract and the Capitation Payments and any cost sharing from Enrollees shall be considered payment in full for all services covered under this Contract.

(C) The Contractor incurs loss if the cost of furnishing the services exceeds the payments under the Contract.

(D) The Contractor may retain all payments under this Contract.

(E) Pursuant to 42 CFR 438.6(e) the Contractor may provide services to Enrollees that are in addition to those covered under the State plan although, the cost of these services cannot be included when determining rates.

(F) The Parties understand and agree that Capitation Rates may only be made by the Department and retained by the Contractor for Medicaid-Eligible Enrollees.

Article 2: Payments

2.1 Payment Schedule

(A) The Department shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the Department's 820 Enrollment Report whether or not the Enrollee receives a Covered Service during that month.

(B) The Parties understand and agree that the Capitation Rates payable by the Department to the Contractor are subject to approval by CMS. The Contractor shall continue to pay the Contractor the rates which were approved by CMS for SFY 2017 until CMS approves the SFY 2018 rates. Upon receiving notification of Capitation Rate approval from CMS, the Department shall recoup previously paid Capitation Payments and replace them with the approved Capitation Rate for the applicable time period. The Department will notify the Contractor upon receiving CMS approval of the rates and the Parties shall execute an amendment to this Contract to include rates approved by CMS.

(C) The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, the Department reserves the right to amend the rates to reflect the change in funding. The Department shall notify the Contractor of any change in the Capitation

Rates due to a loss of funding. When possible, the Department shall make reasonable efforts to notify the Contractor at least 30 days prior to the change in rates.

2.2 Payments for Enrollees in an IMD

In accordance with 42 CFR 438.6(e), the Department may make a monthly Capitation Payment to the Contractor for an Enrollee aged 21-64 receiving inpatient treatment in an IMD so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and the length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.

Attachment F

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