Utah Medicaid
Health Choice Utah
Contract

Accountable Care Organization (ACO)

Effective: July 1, 2024 (SFY 2025)

Attachment A - Utah Department of Health General Provisions

Attachment B – Special Provisions

Attachment C – Covered Services

Attachment D – Quality and Performance

Attachment E – Payment Methodology

Attachment F – Quality Incentive Pool

UTAH DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACT AMENDMENT

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

2318203
DHHS Log Number

232700006
State Contract Number

1. CONTRACT NAME: The name of this contract is ACO - Health Choice Utah SFY23-27 Amendment 4

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health & Human Services (DHHS) and HEALTH CHOICE UTAH INC (CONTRACTOR).

PAYMENT ADDRESS
HEALTH CHOICE UTAH INC
6056 S. Fashion Square Drive, Suite 3940
MURRAY, UT 84107-7355

MAILING ADDRESS
HEALTH CHOICE UTAH INC
6056 S. Fashion Square Drive, Suite 3940
MURRAY, UT 84107-7355

Vendor ID: VC0000166243
Commodity Code: 94842

3. PURPOSE OF CONTRACT AMENDMENT: To update contractual provisions and rates effective July 1, 2024.

4. CHANGES TO CONTRACT:
   1. Updates to attachment B, C, D, E, & F.

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

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective 07/01/2024 .

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

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

Attachment A: UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

NON STANDARD PROCUREMENT (NON-RFP)

1. DEFINITIONS

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

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

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

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

e. “Custom Deliverable” means the Work Product that Contractor is required to deliver to Department under this Contract.

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

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

h. “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.

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

j. “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.

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

l. “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.

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

n. “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.

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

p. "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.

q. “State Data” means all confidential information, non-public data, personal data, and protected health information that is created or in any way originating with the State whether such data or output is stored on the Department’s hardware, Contractor’s hardware, or exists in any system owned, maintained or otherwise controlled by the Department or by the Contractor. State Data includes any federal data that the Department controls or maintains, that is protected under federal laws, statutes, and regulations. The Department reserves the right to identify, during and after the Contract, additional reasonable types of categories of information that must be kept confidential under federal and state laws.

r. “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.

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

t. "Subcontractor" means subcontractors or subconsultants at any tier that are under the direct or indirect control or responsibility of the Contractor, and includes all independent contractors, agents, employees, authorized resellers, or anyone else for whom the Contractor may be liable at any tier, including a person or entity that is, or will be, providing or performing an essential aspect of this Contract, including Contractor’s manufacturers, distributors, and suppliers.

u. “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.

v. “Work Product” means every invention, modification, discovery, design, development, customization, configuration, improvement, process, software program, work of authorship, documentation, formula, datum, technique, know how, secret, or intellectual property right whatsoever or any interest therein (whether patentable or not patentable or registerable under copyright or similar statutes or subject to analogous protection) that is specifically made, conceived, discovered, or reduced to practice by Contractor or Contractor’s Subcontractors (either alone or with others) pursuant to this Contract. Work Product shall be considered a work made for hire under federal, state, and local laws; and all interest and title shall be transferred to and owned by Department. Notwithstanding anything in the immediately preceding sentence to the contrary, Work Product does not include any Department intellectual property, Contractor’s intellectual property (that it owned or licensed prior to this Contract) or Third Party intellectual property.

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

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

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

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

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

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

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

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

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

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

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

    11.2. If Contractor is a recipient entity that, under the terms of the contract, is receiving pass through funding that was neither issued under a competitive award process, nor in accordance with a formula enacted in statute nor in accordance with a state program under parameters in statute or rule that guides the distribution of the pass through funding, Contractor shall provide to the Department a written description and itemized report at least annually detailing the expenditure of the state money, or the intended expenditure of any state money that has not been spent. Contractor shall provide to the Department a final written itemized report when all the state money is spent. The Department

may require Contractor to return an amount of money that is equal to the state money expended in violation of the terms of the section.

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

13. **PAYMENT**:

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

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

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

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

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

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

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

maintain this insurance requirement for the term of the Contract will be grounds for immediate termination of the Contract.

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

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

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

19. **INDEMNIFICATION**:

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

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

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

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

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

22. **TERMINATION AND DEFAULT**:

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

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

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

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

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

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

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

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

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

funds. The Department shall notify Contractor of the Department's action in adjusting the amount of payment or withholding payment. The Contract is executory until such repayment is made.

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

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

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

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

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

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

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

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

only for purposes of the Contract. The Department shall inform Contractor of any non-public designation of any information it provides to Contractor.

29. SECURE PROTECTION AND HANDLING OF STATE DATA:

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

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

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

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

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

31. OWNERSHIP IN INTELLECTUAL PROPERTY: The Department and Contractor agree that each has no right, title, interest, proprietary or otherwise in the intellectual property owned or licensed by the other, unless otherwise agreed upon by the parties in writing. All deliverables, documents, records, programs, data, articles, memoranda, and other materials not developed or licensed by Contractor prior to the execution of this Contract,

but specifically created or manufactured under this Contract shall be considered work made for hire, and Contractor shall transfer any ownership claim to the Department.

32. OWNERSHIP IN CUSTOM DELIVERABLES: In the event that Contractor provides Custom Deliverables to the Department pursuant to this Contract, Contractor grants the ownership in Custom Deliverables, which have been developed and delivered by Contractor exclusively for Department and are specifically within the framework of fulfilling Contractor's contractual obligations under this contract. Custom Deliverables shall be deemed work made for hire, such that all intellectual property rights, title, and interest in the Custom Deliverables shall pass to Department, to the extent that the Custom Deliverables are not recognized as work made for hire, Contractor hereby assigns to Department any and all copyrights in and to the Custom Deliverables, subject to the following:

32.1. Contractor has received payment for the Custom Deliverables,

32.2. Each party will retain all rights to patents, utility models, mask works, copyrights, trademarks, trade secrets, and any other form of protection afforded by law to inventions, models, designs, technical information, and applications ("Intellectual Property Rights") that it owned or controlled prior to the effective date of this contract or that it develops or acquires from activities independent of the services performed under this contract ("Background IP"), and

32.3. Contractor will retain all right, title, and interest in and to all Intellectual Property Rights in or related to the services, or tangible components thereof, including but not limited to (a) all know-how, intellectual property, methodologies, processes, technologies, algorithms, software, or development tools used in performing the Services (collectively, the "Utilities"), and (b) such ideas, concepts, know-how, processes, and reusable reports, designs, charts, plans, specifications, documentation, forms, templates, or output which are supplied or otherwise used by or on behalf of Contractor in the course of performing the Services or creating the Custom Deliverables, other than portions that specifically incorporate proprietary or Confidential Information or Custom Deliverables of Department (collectively, the "Residual IP"), even if embedded in the Custom Deliverables.

32.4. Custom Deliverables, not including Contractor's Intellectual Property Rights, Background IP, and Residual IP, may not be marketed or distributed without written approval by Department.

32.5. Contractor agrees to grant to Department a perpetual, irrevocable, royalty-free license to use Contractor's Background IP, Utilities, and Residual IP, as defined above, solely for Department and the State of Utah to use the Custom Deliverables. Department reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use, for Department's and the State of Utah's internal purposes, such Custom Deliverables. For the Goods delivered that consist of Contractor's scripts and code and are not considered Custom Deliverables or Work Product, for any reason whatsoever, Contractor grants Department a non-exclusive, non-transferable, irrevocable, perpetual right to use, copy, and create derivative works from such, without the right to sublicense, for Department's and the State of Utah's internal business operation under this Contract. Department and the State of Utah may not participate in the transfer or sale of, create derivative works from, or in any way exploit Contractor's Intellectual Property Rights, in whole or in part.

33. SOFTWARE OWNERSHIP: If Contractor develops or pays to have developed computer software exclusively with funds or proceeds from the Contract to perform its obligations under the Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under the Contract, the computer software shall be exclusively owned by or licensed to the Department. If Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from the Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under the Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to Contractor a nontransferable, nonexclusive license to use the software in the performance of the Contract. In the case of software licensed to the Department, the Department grants to Contractor

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

34. WARRANTY OF GOODS:

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

34.2. Notwithstanding the foregoing, any software portions of the Goods that Contractor licenses, contracts, or sells to the Department under the Contract, Contractor agrees that for a period of ninety (90) days from the date of the Department's acceptance that the warranties listed in 34.1 apply to the software portions.

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

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

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

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

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

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

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

41. STANDARD OF CARE: The Services of Contractor 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. Contractor 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 Contractor'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.

42. RECORD KEEPING, AUDITS, & INSPECTIONS:

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

42.2. Contractor shall maintain or supervise the maintenance of all records necessary to properly account for Contractor's performance and the payments made by the Department to Contractor under the Contract. These records shall be retained by Contractor 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. Contractor 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 Contractor as required by GAAP, federal or state law, or specific program requirements, whichever is longer. Contractor agrees to allow, at no additional cost, the State of Utah, federal auditors, and Department staff, access to all such records.

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

42.4. Contractor 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, Contractor must comply with applicable federal cost principles and Contract administration requirements if state funds are received. Counties, cities, towns, and 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.

43. EMPLOYMENT PRACTICES: Contractor 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. Contractor further agrees to abide by any other laws, regulations, or orders that prohibit the discrimination of any kind of any of Contractor's employees.

44. FEDERAL REQUIREMENTS: Contractor 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 Subjects 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) Contractor 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.

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

46. 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.

47. SUBCONTRACTS & ASSIGNMENT: Contractor 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. Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of the Contract that are subcontracted or performed by a Subcontractor. When subcontracting, Contractor agrees to use written subcontracts that conform to federal and state laws. Contractor shall request Department approval for any assignment at least twenty (20) days prior to its effective date.

48. 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.

49. 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.

50. 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.

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

52. **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.

53. **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. Contractor 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 Contractor's failure to timely perform the Services required under the Contract.

54. **DISPUTE RESOLUTION**: The Department and Contractor 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 Contractor, 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 Contractor agree to cooperate in good faith in providing information and documents to the expert or panel in an effort to resolve the dispute.

55. **ANTI-BOYCOTT ISRAEL**: If this contract is in an amount totaling more than $100,000 or if the Contractor has 10 or more full-time employees, then in accordance with Utah Code section 63G-27-201, Contractor certifies that it is not currently engaged in a boycott of the State of Israel and agrees not to engage in a boycott of the State of Israel for the duration of the contract.

56. **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: June 2022)

Attachment B - Scope of Work

Article 1: Introductory Provisions

1.1 Parties

(A) This Contract is between the State of Utah, acting by and through its Department of Health and Human Services (DHHS) which is the Single State agency as specified in the State Plan, hereinafter referred to as "Department" and Health Choice Utah, Inc., hereinafter referred to as "Contractor." Together, the Department and Contractor shall be referred to as the "Parties."

(B) In compliance with 42 CFR § 438.602(i), the Contractor agrees that for the duration of this Contract, the Contractor shall not be located outside of the United States, and that no Claims paid by the Contractor to a Network Provider, Non-Network Provider, Subcontractor, or financial institution located outside of the United States are considered in the development of actuarially sound Capitation Rates.

1.2 Notices

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

(a) certified or registered United States mail, return receipt requested;

(b) personal delivery;

(c) expedited delivery; or

(d) electronic delivery to authorized representative(s) of the Contractor.

Such notices shall be addressed as follows:

Department (if by mail):

Utah Department of Health and Human Services

Division of Integrated Healthcare

Director, Office of Managed Healthcare

P.O. Box 143108

Salt Lake City, UT 84114

Department (if in person):

Utah Department of Health and Human Services

Division of Integrated Healthcare

Director, Office of Managed Healthcare

288 North 1460 West

Salt Lake City, UT 84114

Contractor:

Health Choice Utah, Inc.

P.O. Box 45900

Salt Lake City, UT 84145

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

1.3 Service Area

1.3.1 Service Area, Generally

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

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

1.3.2 Reduction of Service Area

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

1.3.3 Service Area Expansion

The Contractor may not expand into additional Service Areas without the Department's written approval. To request expansion into an additional Service Area, the Contractor must make a written request to the Department and provide any evidence requested by the Department that demonstrates the Contractor's ability to expand into the additional Service Area.

1.3.4 Residency in Service Area

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

1.3.5 Mandatory/Voluntary Enrollment Service Areas

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

Article 2: Definitions

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 result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Medicaid Member practices that result in unnecessary cost to the Medicaid program.

Abuse Potential Medications means drugs that are included in the federal DEA controlled substance schedules C-II through C-V. Also includes, for the purposes of the Restriction Program, Regulated Drugs such as Gabapentin. Regulated drugs are drugs that appear in the Utah Controlled Substance Database but have not been approved as a scheduled drug in Utah. Typically, Utah Regulated drugs have been federally scheduled.

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

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

Adult Expansion Population means the eligible membership limited to parents and adults without dependent children, earning up to 133% (with an additional 5% disregard) of the federal poverty level.

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

Adverse Benefit Determination means:

(1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

(2) the failure to reach a decision on a Service Authorization Request within the required timeframes;

(3) the reduction, suspension, or termination of a previously authorized service;

(4) the denial, in whole or in part, of payment for a service, but not if the denial, in whole or in part, of a payment for a service is solely because the Claim does not meet the definition of a Clean Claim;

(5) the failure to provide services in a timely manner, defined as failure to meet performance standards for appointment waiting times specified in Article 10.2.6 of this attachment;

(6) the failure of the Contractor to act within the timeframes established for resolution and notification of Grievances and Appeals;

(7) for a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise the Enrollee's right to obtain services outside the network; or

(8) the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

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

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

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

Behavioral Health Condition means a mental health disorder, a substance use disorder (SUD) or both.

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

Benefit Issuance Date means the monthly date that the eREP system determines eligibility for the following month. The Department issues capitation payments based on the eligibility information transmitted to the Department from eREP.

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

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

Capitation Rate means the rate negotiated between the Contractor and Department for each Medicaid eligibility group or Capitation Rate cell.

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

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

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

(2) is in Foster Care or another out-of-home placement;

(3) is receiving Foster Care or adoption assistance; or

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

Claim means:

(1) a bill for services;

(2) a line item of services; or

(3) all services for one Enrollee within a bill.

Clean Claim means a Claim that can be processed without obtaining any additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating

from the Contractor's claims system. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse or a Claim under review for Medical Necessity.

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

Comprehensive Risk Contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) outpatient hospital services;

(2) rural health clinic services;

(3) 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 treatment (EPSDT) services;

(7) family planning services;

(8) physician services; and

(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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) means an Agency for Healthcare Research and Quality program, whose purpose is to advance the scientific understanding of patient experience with health care.

Contractor's Restriction Interface means an electronic mechanism by which the Contractor submits Restriction start dates, end dates, PCP, Primary Pharmacy, authorized providers and respective start and end dates for member's Restriction Benefit Plan enrollment to be populated into PRISM.

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

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

Coverage and Reimbursement Code Look-Up Tool means the Department's coverage and reimbursement code database located on the Department's official website. The Coverage and Reimbursement Lookup Tool is a component of the Department's Medicaid policy.

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

Date of Discovery means the date which identification by any State Medicaid agency official or other State official, the federal government, the Provider, or the Contractor of an Overpayment and the communication of that Overpayment finding or the initiation of a formal recoupment action without notice as described in 42 CFR § 433.316.

Delivery Case Rate means a single supplemental payment for maternity delivery costs.

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

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

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

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

Eligibility Transmission means the 834 Benefit Enrollment and Maintenance File.

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

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

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

EPSDT Enrollee means an Enrollee who is eligible to receive EPSDT services in accordance with 42 CFR § 441, subpart B.

Exclusion or Excluded means the temporary or permanent barring of an individual or entity from participation in a Federal Health Care Program and that services furnished, ordered or prescribed by that individual or entity are not paid for under any Federal Health Care Program.

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

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

Family Member means all Medicaid Eligible Individuals associated to the same eligibility case number, included in the Eligibility Transmission, and who are members of the same family.

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

Federal Department of Health and Human Services (HHS) means the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

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

Federal Health Care Program means:

(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code) of the Social Security Act; or

(2) any State Health Care Program, as defined in Section 1128(h) of the Social Security Act.

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

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

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

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

Foster Care or Children in Foster Care means children and youth under the statutory responsibility of DHHS identified as such in eREP.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes Fraud under applicable federal or State law.

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

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

Health Insuring Organization (HIO) means a county operated entity that in exchange for Capitation Payments, covers services for beneficiaries:

(1) through payments to, or arrangements with, providers;

(2) under a Comprehensive Risk Contract with the State; and

(3) meets the following criteria:

(i) first became operational prior to January 1, 1986; or

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

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

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

Healthy Outcomes Medical Excellence (HOME) means the MCO under contract with the Department that is designed to provide services to children and adults with a developmental disability and mental illness and/or behavioral problems. HOME covers both physical and behavioral health services for its enrollees.

Home and Community Based Waiver Services means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver of statutory requirements granted under the provisions of 42 CFR § 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.

Hospital-Acquired Condition (HAC) means a condition occurring in any inpatient hospital setting, defined as a HAC by the Secretary of HHS 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.

Indian means an individual, as defined by 25 U.S.C. § 1603(13), 25 U.S.C. § 1603(28), or 25 U.S.C § 1679(a) or who has been determined eligible, as an Indian, under 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 (IHCP) means a health care program, operated by Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 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.

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

Intermediate Care Facility (ICF) means an institution that provides health related care and services to individuals who do not require the degree of care that hospitals or skilled nursing facilities provide, but because of their physical or mental condition require care and services above the level of room and board.

Intermediate Care Facility for the Intellectually Disabled (ICF/ID) means an intermediate care facility for individuals with intellectual disabilities.

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

Life-Threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

List of Excluded Individuals/Entities (LEIE) means the federal HHS Inspector General's database regarding individuals and entities currently Excluded by the HHS Inspector General 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 https://exclusions.oig.hhs.gov.

Long Term Acute Care (LTAC) means a specialty-care hospital designed for patients with serious medical problems that require intense, special treatment for an extended period of time.

Long Term Care Facility means a facility designed primarily to provide medical care. A Long Term Care Facility includes, but is not limited to: SNFs, ICFs, hospice facilities, and rehabilitation facilities.

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

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

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a Comprehensive Risk Contract, and that is:

(1) a federally qualified HMO that meets the Advance Directives requirements of 42 CFR § 489, subpart I; or

(2) any public or private entity that meets the Advance Directives requirement of 42 CFR § 489, subpart I and is determined by the Secretary of HHS to also meet the following conditions:

(i) makes the services it provides to its Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid or CHIP Members within the area served by the entity; and

(ii) meets the solvency standards of 42 CFR § 438.116.

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

Managed Care Quality Strategy means, in accordance with 42 CFR § 438.340, the Department's written quality strategy for assessing and improving the quality of health care and services furnished by a MCO, PIHP, PAHP, or PCCM entity.

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 the 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 the Contractor's Medicaid product, or either to not enroll in, or to disenroll from another Health Plan's Medicaid product.

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

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

Medicaid Eligible Individual or Medicaid Member means any individual who has been deemed eligible for Medicaid benefits by DHHS or the Utah Department of Workforce Services (DWS).

Medicaid Fee Schedule means a listing of fees that Utah Medicaid reimburses Medicaid Providers who bill Medicaid.

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

Medicaid Information Bulletin (MIB) means the official, periodic publication of the Department. The purpose of MIBs is to provide policy information to Medicaid providers including updates to the Utah Medicaid Provider Manual.

Medical Loss Ratio (MLR) means the calculation the Contractor is required to quantify and report to the Department pursuant to 42 CFR § 438.8.

Medically Necessary or Medical Necessity means medically necessary service as defined by Utah Administrative Code R414-1-2.

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

National Committee for Quality Assurance (NCQA) means a private, non-profit organization dedicated to improving health care quality by evaluating and reporting on the quality of managed care and other health care organizations in the United States. NCQA developed HEDIS and maintains and updates a database of HEDIS results.

National Practitioner Data Bank (NPDB) means the database operated by HHS that contains medical malpractice payment and adverse action reports on health care professionals. The NPDB assists in promoting quality health care and deterring fraud and abuse within health care delivery systems.

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 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 does not have a Network Provider agreement or employment agreement with the Contractor.

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

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

Office of Research and Evaluation (ORE) means the DHHS office responsible for collecting, analyzing and disseminating health care data.

Office of Managed Healthcare (OMH) means the entity within DHHS.

Office of Recovery Services (ORS) means an office within DHHS.

Original Restriction Standardized Review Template (ORSRT) means the Department approved standardized template on which data is recorded and documented for incorporation in the restriction review and decision-making process. This is a longer template than the Short Restriction Standardized Review Template (SRSRT).

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; and

(5) includes, at a 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 Provider by a Managed Care Program to which the 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.

Pass-Through Rebates means all manufacturer-derived revenues the PBM receives for Contractor's claims experience. Rebates mean all manufacturer-derived revenue, including market share or base rebates, price protection, manufacturer administrative fees, however data fees and other fees that manufacturers consider bona fide service fees may be retained by the PBM, but does not remove the PBM's obligation from reporting the bona fide services to the Contractor.

Pass-Through pricing means that the amount billed to the ACO by the PBM will be equal to the amount the PBM paid to the pharmacy, less any point-of-service transaction fees clearly defined between the PBM and the pharmacy provider.

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

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

(1) has an Ownership Interest totaling 5 percent or more in the Contractor;

(2) has an Indirect Ownership Interest equal to 5 percent or more in the Contractor;

(3) has a combination of direct and Indirect Ownership Interests equal to 5 percent or more in the Contractor;

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

(5) is an officer or director of 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.

Pharmacy/Major Services means the Contractor's or the Contractor's subcontractor's scope of work for providing pharmacy services as described in the Utah Medicaid Policy Manual, the State Plan and this contract.

Pharmacy Network Incentives means member steerage to specific pharmacies or own network pharmacies as inducement to financial reward or more favorable reimbursements.

Pharmacy and Therapeutics (P&T) Committee means the committee that provides recommendations for the Medicaid Preferred Drug List (PDL).

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.

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

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

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

Prepaid Inpatient Health Plan (PIHP) means an entity that:

(1) 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;

(2) provides, arranges for, or otherwise has responsibility for the provision of inpatient hospital or institutional services for its Enrollees; and

(3) does not have a Comprehensive Risk Contract.

Prepaid Mental Health Plan (PMHP) means a Managed Care Plan that contracts with the Department to provide to its Enrollees mental health and substance use disorder services, or in one designated area of the State, mental health services only.

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

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

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

PRISM means the Provider Reimbursement Information System for Medicaid.

Prior Authorization see Service Authorization Request.

Provider of Outpatient Drugs means a Utah Medicaid enrolled provider that is authorized to provide covered outpatient drugs to members.

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

Provider Preventable Condition means a condition that meets the definition of a HAC or Other Provider Preventable Condition.

Qualifying Clinical Trial, pursuant to Section 210 of the Consolidated Appropriations Act of 2021, means a clinical trial (in any clinical phase of development) that is conducted in relation to the prevention, detection, or treatment of any serious or Life-Threatening Condition and is described in any of the following clauses:

(1) The study or investigation is approved, conducted, or supported (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Healthcare Research and Quality.

(iv) The Centers for Medicare & Medicaid Services.

(v) A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following if the conditions described in (4) below are met:

(a) The Department of Veterans Affairs.

(b) The Department of Defense.

(c) The Department of Energy.

(2) The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.

(3) The clinical trial is a drug trial that is exempt from being required to have exemptions in (2) above.

(4) For purposes of (1)(vii) above, with respect to a clinical trial approved or funded by The Department of Veteran Affairs, The Department of Defense, or The Department of Energy, are that the clinical trial has been reviewed and approved through a system of peer review that the Secretary of HHS determines:

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

(ii) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

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

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

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

Reconciliation Offsets means a process during annual payment or other time-period based (e.g. quarterly) payment reconciliation between a pharmacy benefit manager and a pharmacy, group of pharmacies, or a collection of unshared pharmacy ownerships (i.e. Pharmacy Service Administrative Organization, PSAOs) that allows the pharmacy benefit manager to offset an amount for overperformance or underperformance of contractual guarantees relative to Utah Medicaid claims with overperformance from other payers, lines of business, network configurations and/or differences in terms and conditions between the ACO contract and the pharmacy contracts (such as brand and generic definitions, day supply, and other exclusion from effective rate calculations).. across guaranteed line items, channels, networks, or payors, as applicable.

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

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

Restricted Enrollee means an Enrollee who is placed in the Restriction Program.

Restriction Electronic Messaging System means the electronic communication tool between the Contractor and the Department for Restriction Program activity.

Restriction Primary Pharmacy means the pharmacy designated by the Department, or the Contractor, as applicable, as the Restricted Enrollee's primary pharmacy as opposed to other approved pharmacies.

Restriction Primary Care Provider or Restriction PCP means the Primary Care Provider designated by the Department, or the Contractor, as applicable, as the Provider who has agreed to be responsible for coordinating the Restricted Enrollee's care.

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

Retrospective Payment Adjustments (e.g. claw-backs, performance adjustments, reconciliation offsets, and other means of adjusting claims payment after point-of-sale (POS) adjudication financial values are transmitted to the pharmacy) means the financial value adjustments (adjustments performed at the claim-level or in the aggregate) a PBM performs to a claim at a pharmacy after a prescription drug has already been dispensed to the patient and paid for by the PBM and/or the patient. Retrospective payment adjustments excludes adjustments

made for erroneous claims submissions, fraudulent claims, or audit findings that result from a desk audit. This could include guaranteed effective rate, performance guarantees, DIR fees, etc.

Risk-Adjusted Base Capitation Payment or Risk-Adjusted Base Capitation Rate means the Capitation Payments excluding any adjustments for risk score settlements, payments for incentive arrangements made under 42 CFR § 438.6, and directed payments included in the Capitation Rate as separate payment terms.

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

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

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

Service Authorization means a process through which a request for provisional approval of coverage is submitted to the Contractor or the Department for review.

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

Short Restriction Standardized Review Template (SRSRT): means the Department approved standardized template on which data is recorded and documented for incorporation in the restriction review and decision-making process. This is a shorter template than the Original Restriction Standardized Review Template (ORSRT).

Skilled Nursing Facility (SNF) means an inpatient rehabilitation and medical treatment center staffed with trained medical professionals.

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

Spread Pricing means the difference between the payments made by a PBM to the pharmacy for a prescription and the charge to the payer for the same claim.

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

State Health Care Program means:

(1) a state plan approved under Title XIX of the Social Security Act;

(2) any program receiving funds under Title V of the Social Security Act or from an allotment to a state under such title;

(3) any program receiving funds under Title XX of the Social Security Act or from an allotment to a state under such title; or

(4) a state child health plan approved under Title XXI of the Social Security Act.

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

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

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

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

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

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

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

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

Ultra High Cost Drug means a covered pharmaceutical drug with a cost being greater than or equal to one million dollars ($1,000,000) per dose as identified by the Department.

Utah Medicaid Integrated Care (UMIC) Plan means a Utah MCO that contracts with the Department to provide medical and behavioral health (i.e., mental health and substance use disorder) services to its Enrollees.

Waste means overutilization of resources or inappropriate payment.

Article 3: Marketing and Enrollment

3.1 Marketing Activities

3.1.1 Marketing, Generally

(A) The Contractor, its employees, Network Providers, agents, or Subcontractors shall not conduct direct or indirect Marketing of the Health Plan except as outlined in Article 3.1.3 of this attachment.

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

3.1.2 Prohibited Marketing Activities

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

(1) directly or indirectly, engaging in door-to-door, telephone, email, texting, 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.

3.1.3 Permitted Marketing Activities

(A) The Contractor shall be allowed to conduct Medicaid related Marketing Activities when the following are met:

(1) the Contractor operates a Qualified Health Plan (QHP) on the federally facilitated marketplace;

(2) the Marketing will only be distributed to persons currently enrolled on the QHP's marketplace product or to persons who are actively seeking enrollment in the QHP's marketplace product;

(3) the Marketing Activities will be limited to print materials and discussions directly with the person. Broad Marketing Activities via media or through public displays are not permitted; and

(4) the purpose of the Marketing Materials is to create continuity for families who may wish to receive services for all Family Members with one plan. In addition, Marketing Materials will help Enrollees transitioning to or from Medicaid to allow continuity of care with their QHP marketplace plan.

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

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

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. Consultation with the Medical Care Advisory Committee may occur only after the Department approves the Marketing Material(s) for use by the Contractor.

3.2.3 Specify Methods

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

3.2.4 Distribution of Marketing Materials

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

3.2.5 Marketing Activities Prohibited

The Department has determined that no Marketing activities specifically directed at Potential Enrollees will be allowed under this Contract except as outlined in Article 3.1.3 of this attachment.

3.3 Enrollment Process

3.3.1 Enrollee Choice

(A) The Department or the Department's designee shall determine eligibility for Enrollment and will offer Potential Enrollees a choice among all Health Plans available in the Service Area.

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

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

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

3.3.2 Period of Enrollment

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

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

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

3.3.3 Open Enrollment

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

3.3.4 Prohibition Against Conditions on Enrollment

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

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

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

basis of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.

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

3.3.5 Independent Enrollment and Enrollment Process

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

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

3.4 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 the Department certifies as being Medicaid-eligible and who have been enrolled in the 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) The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard. The Contractor shall have the ability to receive and process the Eligibility Transmission.

(C) Critical fields found in the Eligibility Transmission shall include:

(1) Enrollee's case number;

(2) case name;

(3) eREP identification number;

(4) name;

(5) date of birth;

(6) date of death;

(7) Social Security number;

(8) gender;

(9) prevalent language;

(10) race;

(11) Capitation Rate Cell;

(12) pregnancy indicator;

(13) copayment/coinsurance indicators;

(14) eligibility start date;

(15) TPL coverage;

(16) county;

(17) address;

(18) phone number; and

(19) if applicable, the Enrollee's Provider under the Restriction Program.

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

(E) In addition to the monthly Eligibility Transmissions, the Department shall send daily Eligibility Transmissions to report changes to the Contractor.

3.4.2 Eligibility Transmission, Specific Types of Enrollees

For purposes of the Eligibility Transmission the following designations apply:

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

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

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

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

3.4.3 Eligibility File, Contractor Responsibilities

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

(B) The Contractor shall follow the policies and procedures found in the Department's 834 Benefit and Enrollment Companion Guide, the HIPAA X12 Benefit Enrollment and Maintenance (834) Implementation Guide, and any amendments to these documents. The Department shall provide any additional instruction in writing to the Contractor. Whenever possible, the Department shall give at least 30 calendar days advance notice of any changes.

3.5 Member Orientation

3.5.1 Initial Contact, General Orientation

(A) The Contractor shall make a good faith effort to ensure that each Enrollee, or the Enrollee's guardian as applicable, receives the Contractor's Enrollee handbook after the Contractor has been notified of the Enrollee's enrollment in the Contractor's Health Plan. The Contractor shall maintain written or electronic records that an Enrollee handbook was provided to each Enrollee.

(B) The Contractor's representative shall make an initial contact with new Enrollees within 10 business days after the Contractor has been notified through the Eligibility Transmission of the Enrollee's enrollment in the Contractor's Health Plan. The Contractor's representative shall verify address, email, phone number and preferred language with the Enrollee and ask if the Enrollee would like to provide race and ethnicity information if not already included in the demographic data. The Contractor shall maintain written or electronic records of such initial contact and demographic data captured.

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

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

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

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

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

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

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

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

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

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

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

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

(C) When an Enrollee is identified as having Special Health Care Needs, the Contractor's representative shall forward this information to a Contractor's individual with knowledge of coordination of care, case management services, and other services necessary for such Enrollees. The Contractor's individual with knowledge of coordination of care for Enrollees with Special Health Care Needs shall make a good faith effort to contact such Enrollees within 10 business days after identification to begin coordination of health care needs, if necessary.

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

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

(1) a Contractor orientation in person or by telephone (or in writing as allowed in Article 3.5.1 of this attachment) has not taken place prior to the Enrollee receiving such services;

(2) the Enrollee had been enrolled in the plan in the previous three months and did not receive an orientation; or

(3) the Enrollee did not receive out-of-network information through the Department either through the Health Program Representative, Medicaid Member Guide, or Health Plan comparison chart.

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

3.6 Enrollee Information

3.6.1 Enrollee Information, Generally

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

(B) The Enrollee information required under Article 3.6 of this attachment 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 without charge upon request and provides it upon request within five business days.

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

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

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

(F) The Contractor shall notify its Enrollees that:

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

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

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

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

(H) The Contractor shall use the Department-developed definition for the following terms:

(1) appeal;

(2) copayment;

(3) durable medical equipment;

(4) emergency medical condition;

(5) emergency medical transportation;

(6) emergency room care;

(7) emergency services;

(8) excluded services;

(9) grievance;

(10) habilitation services and devices;

(11) health insurance;

(12) home health care;

(13) hospice services;

(14) hospitalization;

(15) hospital outpatient care;

(16) medically necessary;

(17) network;

(18) Network Provider;

(19) non-participating provider;

(20) participating provider;

(21) PCP;

(22) physician services;

(23) plan;

(24) preauthorization;

(25) premium;

(26) prescription drug coverage;

(27) prescription drugs;

(28) primary care physician;

(29) provider;

(30) rehabilitation services and devices;

(31) skilled nursing care;

(32) specialist; and

(33) urgent care.

(I) The Department shall provide model Enrollee notices to the Contractor. The Contractor shall ensure all content in the Department's model notices is addressed in the Contractor's notices.

3.6.2 Determining Prevalent Language

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

3.6.3 All Written Materials

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

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

3.6.4 Written Materials Critical to Obtaining Services

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

(B) The Contractor shall include taglines that:

(1) are in the prevalent non-English languages in the State;

(2) are in a conspicuously visible font size;

(3) explain the availability of written translation or oral interpretation to understand the information provided at no cost;

(4) provide information on how to request auxiliary aids and services and that they are provided at no cost; and

(5) include the toll-free and the TTY/TDD telephone numbers of the Contractor's Member Services/customer service unit.

3.6.5 Enrollee Handbook

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

(B) The Contractor shall use the model Enrollee handbook developed by the Department. The Department shall designate which areas in the model Enrollee handbook that the Contractor is allowed to customize.

(C) The Contractor shall ensure that its Enrollee handbook includes information that enables the Enrollee to understand how to use the Contractor's Managed Care Program. This information shall include at a minimum:

(1) benefits provided by the Contractor, including information about the EPSDT benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled with the Contractor;

(2) how and where to access any benefits provided by the Department, including any cost sharing, EPSDT benefits delivered outside the Contractor, if any, and how transportation is provided;

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

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

(5) 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) 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;

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

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

(9) the extent to which and how emergency coverage is provided;

(10) what constitutes an Emergency Medical Condition;

(11) what constitutes an Emergency Service;

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

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

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

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

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

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

(18) Enrollee rights as outlined in Article 9.1.2 of this attachment;

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

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

(21) the Enrollee's right to:

(i) file Grievances and request Appeals; and

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

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

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

(24) the availability of assistance in requesting Appeals;

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

(26) that Indian Enrollees may obtain Covered Services directly from an IHCP;

(27) how to exercise an Advance Directive;

(28) how to access auxiliary aids and services, including additional information in alternative formats or languages, at no cost;

(29) the toll-free telephone numbers for Member Services, medical management, and any other unit providing services directly to Enrollees;

(30) how to report suspected Fraud or Abuse;

(31) a description of the transition of care policies for Enrollees and Potential Enrollees; and

(32) on any other content required by the Department.

3.6.6 Enrollee Handbook Dissemination

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

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

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

(3) posts the information on its website and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet

address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

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

3.6.7 Enrollee Handbook Review and Approval

(A) On or before May 1st of each year, the Contractor shall submit its Enrollee handbook to the Department for review and approval. The handbook shall be submitted to the Department with all changes from the previous version of the handbook tracked.

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

(C) 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 with tracked changes to the Department for review and approval 45 business days before distribution to Enrollees.

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

3.6.8 Enrollee Notice of Significant Change

(A) If the Contractor intends to make any change to its Enrollee handbook, including changes that would impact the information specified in Article 3.6.5(C) of this attachment:

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

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

(B) If the Department identifies a significant change that would impact the information specified in Article 3.6.5(C) of this attachment, the Department shall notify the Contractor in writing within 60 calendar days of the intended effective date of the change.

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

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

3.6.9 Network Provider Directory

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

(1) the Network Provider's name, as well as any group affiliations;

(2) the Network Provider's street address(es);

(3) the Network Provider's telephone number(s);

(4) the Network Provider's website URL, as appropriate;

(5) the Network Provider's specialty, as appropriate;

(6) whether the Network Provider will accept new Enrollees;

(7) the Network Provider's cultural and linguistic capabilities including languages (including American Sign Language) offered by the Network Provider or a skilled medical interpreter at the Network Provider's office; and

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

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

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

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

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

(D) The Contractor shall make the Network Provider directory available on the Contractor’s website in a machine-readable file and format as specified by the Secretary of HHS.

3.6.10 Termination of Network Providers

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

3.6.11 Publication of Covered Medications

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

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

3.6.12 Sales and Transactions

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

3.7 Disenrollment Initiated by Enrollees

3.7.1 Disenrollment by Enrollees in Rural Counties

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

3.7.2 Limited Disenrollment, Generally

The Department requires Enrollees to be enrolled with the same Health Plan for 12 months, except as allowed in Article 3.7.3, Article 3.7.4, and Article 3.8.2 of this attachment.

3.7.3 Limited Disenrollment Without Cause

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

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

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

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

(4) when the Department imposes intermediate sanctions on the Contractor under Article 14.4 of this attachment.

3.7.4 Limited Disenrollment For Cause

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

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

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

(3) other reasons, including poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in dealing with the Enrollee's health care needs;

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

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

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

3.7.5 Process for Requesting Health Plan Change

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

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

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

(D) If the Department fails to make a determination within 10 calendar days after receiving the disenrollment request, the disenrollment is considered approved.

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

3.7.6 Enrollees in an Inpatient Hospital Setting

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

(B) The Department shall retroactively retract enrollment and Capitation Payment(s) from the Contractor when:

(1) the Enrollee is on FFS at the time of admission to the inpatient hospital, or the Enrollee is in an inpatient hospital or nursing home at the time the Enrollee's eligibility starts with the Contractor; and

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

3.8 Disenrollment Initiated by Contractor

3.8.1 Prohibition on Disenrollment for Adverse Change in Enrollee Health

The Contractor may not disenroll an Enrollee because of:

(1) an adverse change in the Enrollee's health status;

(2) an Enrollee's utilization of medical services;

(3) an Enrollee's diminished mental capacity; and

(4) an Enrollee's uncooperative or disruptive behavior resulting from their special needs (except when their continued enrollment seriously impairs the Contractor's ability to furnish services to the Enrollee or other Enrollees).

3.8.2 Valid Reasons for Disenrollment

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

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

(2) violation of responsibilities included in the Contractor's Enrollee handbook;

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

(4) upon termination or expiration of the Contract;

(5) death of the Enrollee;

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

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

(8) as allowed by Article 1.3.24 of Attachment C.

3.8.3 Approval by the Department Required

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

3.8.4 Notice of Disenrollment

If the Department approves the Contractor's disenrollment request, the Contractor shall give the Enrollee written notice of the proposed disenrollment 30 calendar days prior to the effective date of the disenrollment, and shall notify the Enrollee of their opportunity to invoke the Contractor's Grievance process. The Contractor shall give a copy of the written notice to the Department at the time the notice is sent to the Enrollee.

3.8.5 Refusal of Re-Enrollment

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

3.8.6 Automatic Re-Enrollment

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

Article 4: Enrollee Benefits

4.1 General Provisions

4.1.1 Basic Standards

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

(B) The Contractor shall furnish all Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Medicaid Members under FFS, as set forth in 42 CFR § 440.230, and for Enrollees under the age of 21, as set forth in 42 CFR § 441, subpart B.

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

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

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

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

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

(3) family planning services are provided in a manner that protects and enables an Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.

4.1.2 Covered Services

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

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

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

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

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

4.2 Scope of Services

4.2.1 Scope of Covered Services

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

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

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

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

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

4.2.2 Changes to Benefits

Amendments, revisions, or additions to the State Plan or to State or federal regulations, guidelines, or policies, insofar as they affect the scope or nature of benefits available to a Medicaid Member, shall be considered incorporated by this Contract and the Contractor shall be required to provide those benefits to Enrollees. When possible, the Department shall provide written notice to the Contractor of any amendments, revisions, or additions prior to implementation.

4.2.3 Court and Administrative Orders Regarding Benefits

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

4.2.4 Reconstructive Procedures and Least Costly Alternative

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

(1) a reconstructive procedure following disfigurement caused by trauma or caused by Medically Necessary surgery;

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

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

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

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

4.3 Covered Services—Emergency Services

4.3.1 Emergency Services, Generally

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

(B) The Contractor shall cover and pay Providers for Emergency Services, 24 hours a day 7 days a week.

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

(D) The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or Fiscal Agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee’s screening and treatment within 10 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, that the Enrollee may obtain services from a Non-Network Provider without penalty.

(F) The Contractor shall pay Non-Network Providers for Emergency Services in accordance with Article 11.5.2 of this attachment.

4.3.2 Payment Liability for Emergency Services

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

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

(D) In the event an Enrollee presents to an emergency room, the Contractor shall pay for the facility charge and any ancillary services for the entire Emergency Room visit.

4.3.3 Payment Liability in the Absence of a Clinical Emergency

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

4.3.4 Payment Liability for Referrals

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

4.4 Covered Services—Poststabilization Care Services

4.4.1 Poststabilization Care Services, Generally

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

4.4.2 Pre-Approved Poststabilization Care Services

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

4.4.3 Other Contractor-Liable Poststabilization Care Services

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

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

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

(2) the Contractor cannot be contacted; or

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

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

(ii) a Contractor physician assumes responsibility for the Enrollee's care;

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

(iv) the Enrollee is discharged.

4.4.4 Limitation on Charges to Enrollees

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

4.5 Covered Services -- Care Provided in Long Term Care Facilities

4.5.1 Care Provided in Long Term Care Facilities, Generally

It is the responsibility of a Network Provider to make the determination whether the Enrollee shall require the service of a Long Term Care Facility for more or less than 30 calendar days.

4.5.2 Process for Stays Lasting 30 Days or Less

The Contractor shall authorize care for Enrollees in Long Term Care Facilities and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 calendar days.

4.5.3 Process for Stays More than 30 Days

(A) When the Provider’s prognosis indicates an Enrollee requires care in a Long Term Care Facility for more than 30 calendar days, the Contractor shall:

(1) notify the Enrollee and the Long Term Care Facility that the Contractor is only responsible for services provided until the last day of the calendar month of admission, or the last day of the calendar month Medicare coverage of Long Term services ends;

(2) notify the Department that the Enrollee has been admitted to a Long Term Care Facility or that the Enrollee's Medicare coverage has ended and inform the Department of any concerns the Contract has regarding the Long Term Care Facility, including but not limited to, quality concerns, fraud waste or abuse; and

(3) notify the Long Term Care Facility that an admission record needs to be submitted to the Department.

(B) The Department shall disenroll the Enrollee from the Contractor's Health Plan effective the first day of the month following the month of admission or the first day of the month following the loss of Medicare coverage of Long Term Care Services.

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

(A) When the Network Provider's initial prognosis of the Long Term Care Facility services was anticipated to be 30 calendar days or less, but during the 30 calendar day period the Network Provider determines that the Enrollee requires Long Term Care Facility services for more than 30 calendar days, the Contractor shall:

(1) notify the Department that a determination has been made that the Enrollee will require services for more than 30 calendar days within 4 calendar days of discovery; and

(2) notify the Long Term Care Facility that an admission record with the Department must be entered.

(B) The Contractor shall only be responsible for service provided until the last day of the calendar month of admission or the last day of the calendar month in which Medicare coverage of Long Term Care services ends.

4.5.5 Out of Network Long Term Care Facilities

(A) When a Medicaid Enrolled, Long Term Care Facility Provider has an Enrollee with a stay determined to be over 30 days, the Contractor shall authorize the stay and reimburse for medically necessary covered services as described in Article 4.5 of this attachment, even if the Provider is not a Network Provider.

(B) If the Contractor determines that the Enrollee's stay at an out of network Long Term Care Facility should not be covered due to concerns regarding quality, patient care, or fraud, waste, or abuse, the Contractor shall notify the Department. The Department shall be responsible for the Enrollee's care from the date of admission or the day after the end of Medicare coverage of Long Term Care services.

4.5.6 Limitation on Contractor's Financial Liability

The Contractor shall make a good faith effort to follow the provisions of Article 4.5 of this attachment; however, the Contractor shall not be financially responsible for services that are required after the first day of the month following the month of admission or the month in which Medicare coverage of Long Term Care services ends and in no case for any more than 31 days.

4.6 Covered Services – Hospice

4.6.1 Hospice, Generally

If an Enrollee is receiving hospice services at the time of enrollment in the Contractor's Health Plan, the Contractor shall provide a continuation of hospice services. If the Enrollee is already enrolled in the Contractor's Health Plan and a medical professional determines the Enrollee has six months or less to live, the Contractor shall provide the Enrollee with hospice services.

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

4.7 Covered Services—Inpatient Hospital Services for Scheduled Admissions

4.7.1 Financial Responsibility for Inpatient Hospital Services

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

(B) Pursuant to 26B-3-610, for Covered Services delivered to Enrollees enrolled in the Contractor's plan under an Adult Expansion Medicaid eligibility rate, the Contractor shall reimburse hospitals who are Network Providers at no less than the Fee For Service rate.

4.8 Covered Services—Children in Custody of DHHS

4.8.1 Children in Custody of the Utah Department of Health and Human Services, Generally

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

(B) When Contractor's Enrollee is a child who is in the custody of DHHS, the child's care coordination will be directed by DHHS staff. The Contractor shall be responsible for payment of services delivered to the child. The child in custody may continue to use the Provider with whom the child has an established professional relationship when the Provider is a Network Provider. The Contractor shall facilitate timely appointments with the Provider of record to ensure continuity of care for the child.

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

Children staff may assist in performing these functions by communicating with the Contractor.

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

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

4.8.3 Children in Custody, Initial Health Screening

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

4.8.4 EPSDT Exams

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

4.9 Covered Services—Organ Transplantations

4.9.1 Organ Transplantations, Generally

(A) All organ transplantation services are Covered Services for all Enrollees in accordance with the criteria set forth in Utah Administrative Code R414-10A. Both Parties agree that all transplant services will be provided by an in-state Network Provider, unless the service is not available as determined by the Contractor in consultation with its Network Providers. In this case, the service must be performed by an in-state Non-Network Provider or an out-of-state Provider.

(B) In accordance with Section 1903(i) of the Social Security Act, the Contractor is prohibited from paying for organ transplantations unless the Contractor follows the criteria set forth in the State Plan, Utah Administrative Code R414-10A and ensures that similarly

situated individuals are treated alike and that any restrictions on facilities or Providers be consistent with the accessibility of high-quality care to Enrollees.

4.9.2 Specific Organ Transplantations

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

4.9.3 Psychosocial Evaluation Required

Enrollees who have applied for organ transplantations, except for cornea or kidney transplantations, shall undergo a comprehensive psychosocial evaluation. The evaluation shall include a comprehensive history regarding substance use and compliance with medical treatment. In addition, the parent(s) or guardian(s) of Enrollees who are less than 18 years of age shall undergo a psycho-social evaluation that includes a comprehensive history regarding substance use, and past and present compliance with medical treatment.

4.9.4 Out-of-State Transplantations

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

4.10 Covered Services—Mental Health and Substance Use Disorders

4.10.1 Mental Health and Substance Use Disorders, Generally

When an Enrollee presents with a possible mental health or substance use disorder to the Enrollee's Primary Care Provider, it is the responsibility of the Primary Care Provider to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist. Mental health or substance use disorders may be handled by the Primary Care Provider or referred to the Enrollee's PMHP when more specialized services are required for the Enrollee.

4.11 Excluded Services—Habilitative and Behavioral Management Services

4.11.1 Habilitative Services and Behavioral Management Services, Generally

Habilitative services and Behavioral Management Services are not Covered Services. If habilitative services are required, the Contractor shall have a process to refer the Enrollee to the

Division of Services for People with Disabilities (DSPD), the school system, the Early Intervention Program, or similar support agency. The Enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD. Habilitative services are defined in Section 1915(C)(5)(a) of the Social Security Act as "services designed to assist individuals in requiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."

4.12 Covered Services—Out-of-State Transportation Services

4.12.1 Out-of-State Transportation, Generally

(A) When the Contractor elects or arranges to have an Enrollee receive services from an out-of-state Provider, the Contractor shall be responsible for the applicable out-of-state transportation, either emergent or non-emergent, and related costs for the Enrollee and, if necessary, for a parent, guardian, and/or attendant.

(B) The Contractor shall follow the Department's criteria for out-of-state transportation and related costs including food, and lodging, as outlined in the Utah Medicaid Provider Manual for Medical Transportation.

(C) The Contractor is not responsible for transportation expenses, either emergent or non-emergent, for an Enrollee who has a medical condition that occurs while out-of-state and must return to the State for treatment or services.

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

4.13.1 Identification of Enrollees with Special Health Care Needs

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

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

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

4.13.2 Primary Care Provider for Enrollees with Special Health Care Needs

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

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

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

4.13.3 Referrals and Access to Specialty Providers

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

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

4.13.4 Collaboration with Other Programs

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

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

(C) The Contractor shall, as appropriate, coordinate medical health care needs for Enrollees with Special Health Care Needs with the services of other entities or providers such as public health departments, transportation providers, home and community-based services providers, developmental disabilities services providers, Title V providers, local schools, IDEA programs, and child welfare agencies.

4.13.5 Case Management and Care Coordination Program

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

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

(C) The Contractor shall retain ultimate responsibility for case management and care coordination services even if using a Provider or third party contractor for delivery of the services.

(D) A case management program may include, but is not limited to:

(1) methodologies to determine the frequency and duration of case management services through application of the Contractor's criteria;

(2) mechanisms to refer to and coordinate with other State agencies and community resources as necessary;

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

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

(5) referral of Enrollees to Medical Homes, where appropriate; and

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

4.14 Pharmacy Benefits

4.14.1 General Requirements

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

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

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

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

(E) The Contractor shall have a copayment accumulator capable of tracking pharmacy copays made by the Contractor's Enrollees.

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

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

4.14.2 Covered Drugs, PDL-Plus File

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

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

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

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

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

(4) the durable medical equipment which the Contractor is responsible for covering as a pharmacy benefit;

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

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

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

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

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

4.14.3 Non-Covered Drugs

In calculating the Capitation Rate, the Department shall not include as service costs drugs which have not been prescribed by an enrolled Utah Medicaid Provider, except as provided in 5.3.1 of this Attachment.

4.14.4 Rebateable Drugs

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

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

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

manufacturers. The quarterly and annual reports shall be in a format designated by the Department.

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

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

4.14.5 Provider Enrollment with Medicaid

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

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

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

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

4.14.6 Preferred Drug List

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

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

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

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

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

(ii) The Department's P&T Committee may require the Contractor to amend its PDL if the Board determines that the Contractor's PDL violates this Contract, violates applicable State and federal laws, or appears to create an adverse selection process;

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

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

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

4.14.7 Enrollees Eligible for Medicare Part D

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

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

4.14.8 Federal Drug Utilization Review Reporting

(A) The Contractor shall assist the Department in collecting any data that the Department needs to complete the federal drug utilization review report.

(B) The Contractor shall provide the Department with any information requested by the Department to complete the federal drug utilization review report within 30 calendar days of the Department's request. If the Contractor fails to respond to the request in a timely manner, the Department may impose sanctions as allowed in Article 14 of this attachment.

4.14.9 Special Rules for 340B Drug Pricing Program

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

(B) In the event that the Contractor's Network Providers elect to use drugs purchased under the 340B Drug Pricing Program, the Contractor shall identify on its Encounter Data, all Claims reported by Providers that utilized 340B stock by the following methods.

(1) For point-of-sale pharmacy Claims, the Contractor's Network Provider shall identify the 340B stock by adding a value of "20" to the submission clarification code field on the pharmacy Claim. By indicating on the NCPDP Post-Adjudication History File, the Contractor is certifying that the prescription satisfies all requirements for 340B drug as described in Public Law 102-525, Codified in Section 340B of the Public Health Services Act, and it's implementing regulations.

(2) For Provider administered Claims, the Contractor's Network Provider shall identify the 340B stock by adding the 'UD' modifier after each of the applicable 340B eligible HCPCS code(s) on each Claim line.

(3) For Provider-administered Medicare Crossover Claims, the Contractor's Network Provider shall identify the 340B stock by adding the 'JG' or 'TB' modifier after each of the applicable 340B eligible HCPCS code(s) on each Claim line.

(C) The Department, on a quarterly basis, shall invoice the Contractor for the Medicaid Drug Rebate equivalent associated with 340B dispensed drugs based on the 340B indicator submitted by the Contractor on the Encounter Data. The Contractor shall pay the Department within 30 calendar days of the date of the invoice.

4.14.10 Additional Pharmacy Requirements of the Social Security Act

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

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

4.14.11 Drug Utilization Review Program

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

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

4.14.12 SUPPORT Act Requirements

(A) The Contractor shall comply with Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act requirements as described in H.R. 6.

(B) The Contractor shall include in its DUR program the following as described in the SUPPORT Act:

(1) Claims review requirements that include:

(i) safety edits, including early, duplicate, and quantity limits;

(ii) prospective safety edits for subsequent fills for opioids; and

(iii) an automated process that indicates when an Enrollee is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the Department.

(2) Maximum daily Morphine Milligram Equivalents (MME) safety edits that include:

(i) prospective safety edits on maximum MMEs that can be prescribed to an Enrollee for treatment of chronic pain; and

(ii) a Claims review automated process that indicates when an Enrollee is prescribed the morphine equivalent for such treatment in excess of the maximum MME dose limitation as identified by the Department.

(3) Concurrent utilization alerts through an automated process for Claims review that monitors when an Enrollee is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

(4) Methods to assist with coordination of care and the monitoring and management of antipsychotic medication utilization in children through 18 years, and Children in Foster Care.

(5) Identification requirements related to the Fraud and Abuse of controlled substances by Enrollees enrolled under the State Plan, health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

(C) The above requirements in Article 4.14.12(B) of this attachment do not apply to Enrollees who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a

contact with a single pharmacy; or other individuals the Department elects to treat as exempted from such requirements.

4.14.13 Opioid Reduction Strategies

(A) The Contractor shall develop methods to reduce opioid utilization through MME methodology and MED (Morphine Equivalent Dose) cumulative dosing limits. In coordination with the Drug Utilization Review Board and Department FFS pharmacy policy, the Contractor shall apply a prospective drug utilization edits which prevent Enrollees from obtaining additional opioids beyond the MME/MED limit determined by the Department. There will be a separate standard for Enrollees who are opioid naïve and opioid experienced.

(B) Opioid naïve Enrollees will have a lower MME/MED threshold than those currently taking an opioid (defined as an individual who has had a Claim for an opioid in the last 90 calendar days from the index prescription date). The MME/MED threshold set by the Department for opioid naïve Enrollees will align with CDC standards.

(C) Exceptions to the MME/MED requirements can be made for Enrollees with a valid cancer diagnosis or in other unique situations through a prior authorization.

(D) The Contractor shall transition opioid experienced Enrollees exceeding the MME/MED dosing limit gradually over time to fall into the limits derived by the Department.

(E) The Contractor shall come into compliance with the MME/MED standards established by the Department within 60 calendar days of receipt of a notice of changes to the Department's established MME/MED standard.

(F) The Contractor may utilize an alternative MME/MED standard that aligns with the SUPPORT Act standards upon approval from the Department.

4.14.14 PBM Transparency

(A) The Contractor shall ensure that all pharmacy benefit managers (PBM) and/or pharmacy benefit administrators (PBA) performing Pharmacy/Major Services on behalf of the Contractor shall provide Pass-Through Pricing models where Spread Pricing and Retrospective Payment Adjustments, and Pharmacy Network Incentives are prohibited and provide pass-through of all Rebates to Contractor.

(B) The Contractor and its delegated PBM shall be prohibited from utilizing non-transparent pricing strategies or tactics which preclude the State of Utah from understanding the economic value of the pharmacy benefit that would otherwise be retained by the PBM, PBA or the Contractor.

(C) The Contractor or the Contractor's PBM is prohibited from recouping or withholding any fees paid to a Provider of Outpatient Drugs via reconciliation or 835 transaction at a claim-

level or provider-level balance (PLB) adjustment, or any other monetary recoupments as related to discounts, quarterly or annual Reconciliation Offsets, direct or indirect remuneration (DIR) fees, and any other instance where a fee may be recuperated from a pharmacy and/or provider.

(1) Fees may be recouped for specific instances upon approval by DHHS such as.

(i) instances of fraud or abuse.

(ii) claims adjudicated in error.

(iii) claims identified as an overpayment.

(iv) payments tied to value-based purchasing agreements on quality outcomes.

(D) Proprietary Information Disclosures

(1) If the Contractor deems specific data or information related to pharmacy services or administration, including agreements with the Contractor's PBM as 'proprietary information', then the Contractor shall.

(i) report the specific proprietary information on the ACO PBM Transparency Report provided by the Department.

(ii) the Department will not disclose the proprietary information as indicated on the ACO PBM Transparency Report.

(E) The Contractor shall report PBM transparency metrics to the Department on November 1st of each year for the previous SFY period, unless otherwise specified below, including:

(1) all financial terms and arrangements for payment of any kind that apply between the Contractor or the Contractor's PBM and any Provider of Outpatient Drugs, any prescription drug manufacturer, prescription drug wholesaler, or labeler.

(2) description of which Pharmacy/Major services are operationalized by the Contractor and which are subcontracted to the PBM, including the following.

(i) claims adjudication.

(ii) Prior Authorization.

(iii) call center/customer service.

(iv) utilization management (pharmacy case management and retro DUR); and.

(v) rebate aggregation.

(3) upon request from the Department, copies of its model PBM pharmacy provider agreement(s) and notate any differences among commercial, preferred, or independently owned pharmacies.

(4) PBM pricing elements as described, at a minimum, by the major services of their contract, subcontract or agreement with the Contractor.

(i) Identify network(s) the Utah Medicaid claims are processed under and the terms of the network(s).

(ii) price per pharmacy claim adjudicated (include any and all pharmacy claim types).

(iii) price per prior authorization, broken out by the following categories.

(a) general PA (quantity limit, step therapy).

(b) clinical PA; and.

(c) Appeals and hearing.

(iv) price per member intervention or engagement.

(a) Tier 1 - customer service.

(b) Tier 2 - pharmacist; and.

(c) Tier 3 - escalation to medical director.

(v) rebates collected at the NDC-11 level.

(vi) data storage costs attributed to the Contractor's Utah Medicaid pharmacy services.

(vii) data security costs attributed to the Contractor's Utah Medicaid pharmacy services; and.

(viii) administrative costs (not outlined above).

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 Covered Services for all Enrollees, including those with limited English proficiency, physical

disabilities, and/or mental disabilities. In establishing and maintaining the network of Network Providers the Contractor shall consider:

(1) the anticipated Medicaid enrollment;

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

(3) the numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the Covered Services;

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

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

(B) The Contractor shall demonstrate that its network includes sufficient family planning Network Providers to ensure timely access to Covered Services.

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

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

5.1.2 Time and Distance Standards

(A) The Contractor shall maintain provider network adequacy time and distance standards to ensure Enrollee access. The standards will be different for Frontier, Rural and Urban areas of the State. Wasatch Front Urban, Rural and Frontier areas of Utah are listed in Table 2 - Time and Distance Standards.

Table 1 - County Designation

Urban Counties	Rural Counties	Frontier Counties
Cache	Carbon	Beaver
Davis	Iron	Box Elder
Salt Lake	Morgan	Daggett
Utah	Sanpete	Duchesne
Weber	Sevier	Emery
	Summit	Garfield
	Wasatch	Grand
	Washington	Juab
		Kane

		Millard
		Piute
		Rich
		San Juan
		Tooele
		Uintah
		Wayne

(B) The Contractor shall ensure that Enrollees have access to the following types of Network Providers within the time and distance standards.

Table 2 - Time and Distance Standards

Provider or facility Type	Urban Counties	Rural Counties	Frontier Counties
Primary Care - Adult	90% of members must have access within 10 miles or 15 minutes	90% of members must have access within 35 miles or 45 minutes	90% of members must have access within 60 miles or 70 minutes
Primary Care - Pediatric	90% of members must have access within 10 miles or 15 minutes	90% of members must have access within 35 miles or 45 minutes	90% of members must have access within 60 miles or 70 minutes
OB/GYN	90% of members must have access within 10 miles or 15 minutes	90% of members must have access within 35 miles or 45 minutes	90% of members must have access within 60 miles or 70 minutes
Specialist - Adult	90% of members must have access within 30 miles or 45 minutes	90% of members must have access within 80 miles or 100 minutes	90% of members must have access within 110 miles or 125 minutes
Specialist - Pediatric	90% of members must have access within 30 miles or 45 minutes	90% of members must have access within 80 miles or 100 minutes	90% of members must have access within 110 miles or 125 minutes
Hospital	90% of members must have access within 30 miles or 45 minutes	90% of members must have access within 60 miles or 80 minutes	90% of members must have access within 100 miles or 110 minutes
Pharmacy	90% of members must have access within 10 miles or 15 minutes	90% of members must have access within 35 miles or 45 minutes	90% of members must have access within 60 miles or 70 minutes

(C) If the Contractor is unable to meet the network adequacy standards described in Article 5.1.2 of this attachment, the Contractor may request an exception to these standards. The Department has sole discretion to allow for any exception to the network adequacy standards. A request for exception to these standards must be in writing and must include:

(1) the specific exemption the Contractor is requesting;

(2) the steps taken by the Contractor to comply with the network adequacy requirements before requesting the exception; and

(3) a description of the Contractor's plan to adequately provide Covered Services in the area where the exemption is requested.

5.1.3 Women's Health Specialists

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

5.1.4 Second Opinions

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

5.1.5 Out-of-Network Services

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

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

5.1.6 Timely Access

(A) The Contractor and its Network Providers shall meet the Department's standards for timely access to Covered Services, as described in Article 10.2.6 of this attachment, taking into account the urgency of the need for services.

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

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

5.1.7 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements to meet performance standards for appointment waiting times specified in Article 10.2.6 of this attachment 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 against the Network Provider.

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

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

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

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

(1) comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions;

(2) agree that the Department, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract;

(3) make available, for the purposes of an audit, evaluation, or inspection by the Department, CMS, the HHS Inspector General, the Comptroller General, or their

designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Enrollees;

(4) agree that the right to audit by the Department, CMS, the HHS Inspector General, the Comptroller General, or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

(5) agree that if the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

5.2.2 Agreements with Providers and Subcontractors

(A) The Contractor shall inform Providers and Subcontractors at the time they enter into a Network Provider agreement or a Subcontract about:

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

(2) the Enrollee's right to file Grievances and Appeals, and the requirements and timeframes for filing a Grievance or Appeal;

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

(4) 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; and

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

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

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

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

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

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

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

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

(3) the Provider or Subcontractor shall not hold Enrollees liable for payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor covered the services directly.

5.2.3 Additional Network Provider Requirements

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

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

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

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

(E) The Contractor shall ensure its Network Providers are enrolled with the Department.

5.2.4 Mandatory Network Provider Agreements

(A) The Contractor must enter into a Network Provider agreement with:

(1) a level one trauma facility;

(2) a trauma intensive care burn center that includes:

(i) an operating room;

(ii) burn therapy services;

(iii) outpatient departments;

(iv) support activities for burn survivors; and

(v) services for both adults and children; and

(3) Primary Children's Hospital.

(B) If the Contractor is unable to attain a commercially reasonable and actuarially sound contract with the providers listed in Article 5.2.4(A) of this attachment, the Contractor may present an alternative plan for approval by the Department to ensure network adequacy is maintained.

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

(A) The Contractor shall only make payments to Providers who are enrolled with the Department, except when the Provider is:

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

(2) involved in delivery of Emergency Services that does not meet the definition of a Network Provider per 42 CFR § 438.2; or

(3) a Network Provider, pending enrollment with the Department, per 438.602 (b)(2).

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

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

(1) the Department notifies the Contractor that the Network Provider cannot be enrolled;

(2) the Provider notifies the Contractor that they cannot be enrolled by the Department; or

(3) one 120-day period has expired without enrollment of the Provider by the Department.

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

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

5.3.2 Network Provider Selection

(A) The Contractor shall have written policies and procedures for selection and retention of Network Providers that include the requirements found in this Contract.

(B) The Contractor shall comply with any additional Network Provider selection requirements required by the Department. The Department shall provide the Contractor 60 calendar days advance written notice of any changes to the Department's Network Provider selection requirements.

5.3.3 Credentialing and Recredentialing 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 recredentialing Network Providers.

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

(C) If the Contractor uses a certified Credentials Verification Organization (CVO) to perform LEIE and SAM Exclusion searches, and if the certified CVO also performs the verifications required in Article (B)(3) above, the CVO searches satisfy this requirement. The Contractor may use the NPDB to satisfy the verifications required in Article (B)(3) above as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on licensure and disciplinary status.

(1) Network Provider completion of Contractor written applications;

(2) procedures for assuring that potential and current Network Providers are appropriately credentialed;

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

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

5.3.4 Timeframe for Recredentialing

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

5.3.6 Documentation

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

5.3.7 Non-Inclusion of Providers

(A) The Contractor shall report to the Department when a Provider is denied Network Provider status. Such denial can include when a Provider is denied admission to the Contractor's provider panel, is removed from the Contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of DOPL 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 enter into a Network Provider agreement with at least one Federally Qualified Health Center within the Service Area.

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

(C) The Contractor shall reimburse the FQHC an amount not less than what the Contractor pays comparable Providers that are not FQHCs.

5.3.10 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall adopt practice guidelines consistent with current standards of care. The practice guidelines shall:

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

(2) consider the needs of the Contractor's Enrollees;

(3) be adopted in consultation with Network Providers; and

(4) be reviewed and updated periodically as appropriate.

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

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

5.4 Payment of Provider Claims

5.4.1 General Requirements

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

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

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

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

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

(F) If the Department has paid a Provider FFS for a Covered Service and the Medicaid Member's eligibility is changed retroactively resulting in a retroactive Capitation Payment to the Contractor, and if the Department or an audit entity retracts the FFS payment solely due to the retroactive eligibility change, the Contractor:

(1) shall pay Claims submitted by the Provider;

(2) shall not require a Service Authorization Request; and

(3) shall not deny the Claim due to timely filing.

5.4.2 Special Rules for Payment for Provider Preventable Conditions

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

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

5.4.3 FQHC and Rural Health Clinic Payments

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

(B) The Contractor shall pay out of state FQHCs and RHCs the Prospective Payment System rate effective in that state.

5.4.4 Vaccines for Children Program

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

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

5.5 Prohibitions on Payment

5.5.1 Prohibitions on Payments for Excluded Providers

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

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

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

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

(B) If the Contractor suspends payment pursuant to Article 5.5.1(A)(3) of this attachment, the Contractor shall immediately send written notice to the Department of its intent to suspend payment and shall supply any information regarding the suspension and the allegation of Fraud as requested by the Department.

5.5.2 Additional Payment Prohibitions under federal law

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

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

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

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

(B) Pursuant to Section 1903(i)(2), 42 CFR § 438.808, § 1001.1901(c), and § 1002.3(b) the Contractor may not:

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

(2) have 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 FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(iii) any 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) employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

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

(ii) any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

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

(C) 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 Directed Payments to Providers

5.6.1 Directed Payments- Hospitals

(A) In accordance with the 42 CFR § 438.6(c)(2)(ii)(B), the Contractor shall be required to pay a per diem add-on payment for all private hospital paid inpatient days and the State teaching hospital. The Department, through its contracted Actuary, shall identify a portion of the Capitation Rates, which will be multiplied by the member months to identify the total directed payment pool. The directed payment pool will be aggregated with amounts from all Health Plans contracted with the Department.

(B) The Department shall use all paid inpatient days data received from the Department's contracted Health Plans during the month to determine the number of paid inpatient days. For each Contractor, the Department shall divide the number of inpatient days against the directed payment pool to establish a uniform per diem add on to be paid by the Contractor to private inpatient hospitals.

(C) In the event that an inpatient Encounter is voided, retracted or otherwise found to be invalid and the inpatient Encounter was used in the calculation of a prior directed payment, the Department shall offset that inpatient encounters used in a subsequent month's calculation.

(D) If a hospital's final SFY directed payment is a negative amount, the Department shall instruct the Hospital to return the owed amount to the Contractor.

(E) The Contractor shall pay the Department the recovered Directed Payment it receives from the hospital within 30 calendar days of receipt. If the Contractor fails to pay the department within 30 days of receipt of the Directed Payment from the hospital, the Department may suspend payments to the Contractor until the Department receives the full amount.

(F) In the event that the Contractor does not complete the directed payment process as established, the Contractor shall be subject to the measures in Article 14 of this attachment, including but not limited to corrective action or liquidated damages.

5.6.2 Directed Payments-University of Utah Medical Group Providers (UUMG)

In accordance with 42 CFR § 438.6(c)(2)(ii)(B), the Contractor shall be required to pay UUMG a specified amount each month. An identified portion of the actuarially sound per member per month Capitation Payment to the Contractor for UUMG multiplied by the member months for the paid month will form a pool. The directed payment pool will be aggregated with amounts from all Health Plans contracted with the Department. At the end of each month, the Contractor shall be directed to pay to the UUMG an amount which is anticipated to result in UUMG being paid similar to average commercial rate (ACR) levels.

5.6.3 Directed Payment Processes- All

(A) Monthly, the Department shall publish a report on the Utah Medicaid webpage describing the amounts the Contractor shall pay to each hospital and to UUMG.

(B) The Contractor shall complete the directed payment process by the reconciliation date listed on the Medicaid webpage for each payment period.

(C) The Contractor shall return a completed Directed Payment report documents to the Department by the Reconciliation Due date listed on the Utah Medicaid webpage that documents all payments made to hospitals or UUMG in accordance with this section.

(D) Prior to the distribution of the funds to allow the Contractor to process the Directed Payments, the Department shall perform payment prohibition screenings on Providers who will receive any directed payment.

(E) The Contractor shall return any portion of any directed payment identified by the Department as not earned by a hospital based on the hospital's quality measure performance.

5.6.4 Legislative Directed Allocations

The Contractor shall ensure that one-time or recurring funding allocations are implemented as directed by the legislature.

5.7 Directed Payments-American Recovery Plan Act (ARPA)

(A) Quarterly, the Department shall send the Contractor a supplemental payment report detailing the Contractor's Providers and the amount of each Provider's ARPA supplemental payment.

(B) The Contractor shall pay each Provider the amount specified in the directed payment report within 30 calendar days from the date the Department sends the directed payment dollars and the directed payment report to the Contractor.

(C) The Contractor shall submit to the Department a completed supplemental payment report confirming payment to Providers within 45 calendar days from the date the Department sends the supplemental payment report to the Contractor.

Article 6: Program Integrity Requirements

6.1 Fraud, Waste, and Abuse

6.1.1 Fraud, Waste, and Abuse, Generally

(A) Pursuant to 42 CFR § 438.608, the Contractor or Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of Claims, shall implement and maintain arrangements or procedures, including a mandatory compliance 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 or Subcontractor shall have a written compliance plan designed to identify and refer suspected Fraud, Waste, or Abuse activities.

(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 plan 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 plan shall include a description of the Contractor’s payment suspension process and how this process is in compliance with Article 6.1.5 of this attachment.

(F) The Contractor shall submit the compliance plan to the Department by July 1st of each year which shall be subject to the Department's approval. If the Department does not provide a response to the Contractor within 90 calendar days of receiving the compliance plan, it will be deemed approved.

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

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

6.1.2 Specific Requirements for Contractor's Management Arrangements or Procedures

The Contractor (and Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payments of Claims) shall implement and maintain management arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Abuse that shall include:

(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 who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors;

(3) a regulatory compliance committee that is accountable to the Board of Directors and is at the senior management level and is charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract;

(4) a system for training and education for the compliance officer, the Contractor's senior management, and the Contractor's employees on the federal and State standards and requirements under this Contract;

(5) effective lines of communication between the compliance officer and the Contractor's employees;

(6) enforcement of standards through well-publicized disciplinary guidelines;

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

(8) provisions for internal monitoring and auditing including:

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

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

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

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

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

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

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

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

6.1.3 Reporting Potential Contractor or Provider Fraud, Waste, or Abuse

(A) Pursuant to Utah Code Ann. § 63A-13-101 et seq., if the Contractor or a Provider becomes aware of potential Provider-related Fraud, Waste, or Abuse, the Contractor or the Provider shall report the incident, in writing, to the Utah OIG (mpi@utah.gov). The Contractor may additionally report the incident to MFCU (MFCUComplaints@agutah.gov).

(B) If the Contractor or Provider reports an incident to the Utah OIG, the Contractor or Provider shall electronically submit a copy of the report to the Department at mc-fwa@utah.gov.

(C) Reports of Fraud, Waste, or Abuse made by the Contractor or a Provider shall be made to the Utah OIG and the Department within 15 business days of detection of the incident of Provider-related Fraud, Waste, or Abuse, subject to the exception for Waste in Utah Code Ann. 63A-13-501(1)(b).

(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) On a quarterly basis, the Contractor shall submit to the Department, using the Department-specified form, a report that includes:

(1) in accordance with 42 CFR § 455.17(a), the number of complaints of Fraud, Waste, and Abuse that warranted a preliminary investigation;

(2) in accordance with Utah Code Ann. §63A-13 et seq., the number of incidents of potential Fraud, Waste, or Abuse reported to the OIG; and

(3) the Providers against which the Contractor has taken any adverse action for Fraud, Waste or Abuse, and a description of the adverse action taken.

6.1.4 Reporting Potential Medicaid Member Fraud, Waste, or Abuse

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

6.1.5 Obligation to Suspend Payments to Providers in Cases of Fraud

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

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

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

6.1.6 Service Verification

(A) The Contractor shall have written policies and procedures to verify, by sampling or other methods, that services billed by Providers were received by the Contractor's Enrollees.

(B) If the Contractor uses sampling procedures specified below to verify that services were provided, the Contractor's written policies and procedures must include that:

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

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

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

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

(iii) the method of contact;

(iv) whether the Enrollee responded to the contact; and

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

(3) the Contractor shall keep copies of correspondence.

(C) If the Contractor uses methods other than the sampling procedures specified in Article 6.1.6(B) of this attachment to verify services billed by Providers were received by the Contractor's Enrollees, the Contractor's written policies and procedures shall include a detailed description of the method(s) to be used.

(D) The Contractor shall submit an annual SFY report to the Department by November 1st of each year, in a Department-specified format, documenting that service verifications were performed.

6.1.7 Subrogation of Claims Arising from Fraud

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

6.1.8 Electronic Visit Verification (EVV)

(A) The Contractor shall collaborate with the Department to comply with the EVV requirements as contained in Section 12006 of the 21St Century Cures Act, and Section 1903(l) of the Social Security Act (SSA).

(1) The Department shall conduct the EVV Claim reviews to validate that the EVV occurred.

(2) The Contractor shall ensure that Claim fields related to the EVV activity are transmitted through Encounter Data to the Department as specified in Article 12.3 of this attachment.

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 employees (including management) and its contractors or agents which comply with the Act.

(B) For purposes of Article 6.2 of this attachment, 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 and Procedures

The Contractor's written policies and procedures shall provide detailed information about:

(1) 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.

6.2.3 Dissemination of False Claims Act Policies and Procedures

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

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

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

6.3 Prohibited Affiliations

6.3.1 General Requirements

(A) In accordance with Section 1932(d) of the Social Security Act and 42 CFR § 438.610 the Contractor shall not knowingly have:

(1) a director, officer, partner, Subcontractor as governed by 42 CFR § 438.230, or person with beneficial ownership of 5% or more of the Contractor's equity who is:

(i) debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or

(ii) an affiliate, as defined in FAR, of a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or

(2) 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 FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or

(ii) an affiliate, as defined in FAR, of a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement 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.

(C) Pursuant to 42 CFR § 455.101, the Contractor shall not contract with Providers that the Department has determined to be terminated from federal participation in any Federal Health Care Program.

6.3.2 Screening for Prohibited Affiliations

(A) The Contractor shall maintain written policies and procedures for conducting routine searches for prohibited affiliations. Whenever a search of the LEIE and SAM, and any other database required by the Department, is required in this Contract, the Contractor may use:

(1) a certified Credentials Verification Organization (CVO) as long as the Contractor's written policies and procedures address selection of a CVO and that the Contractor may only use a CVO that:

(i) is certified by NCQA or other organization that offers a CVO certification program.

(ii) provides evidence of LEIE and SAM searches that include the dates of the searches.

(2) the NPDB as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on Exclusions.

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

(1) directors, officers, or partners of the Contractor;

(2) Subcontractors as governed by 42 CFR § 438.230;

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

(4) Network Providers; 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 obligations under this Contract.

(C) Before entering into a relationship with the individuals or entities listed in Article 6.3.2(B) of this attachment the Contractor shall, at minimum:

(1) conduct searches of the LEIE and SAM databases and any other database required by the Department to ensure that the individuals listed in Article 6.3.2(B) of this attachment are not debarred, suspended, or otherwise Excluded; and

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

(D) If the individuals or an entity listed in Article 6.3.2(B) of this attachment are not found in the database searches, the Contractor shall determine if the individual or entity is an affiliate, as defined by FAR, of a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

(1) To determine if the individuals or entities listed in Article 6.3.2(B) of this attachment are an affiliate of a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under FAR 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 obtain written attestations from the individuals or entities stating whether they are an affiliate, as defined by FAR, of an individual or entity that has been debarred, suspended or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

(2) The Contractor's written attestation shall include a statement that if the individual or entity completing the written attestation subsequently becomes an affiliate of a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the individual or entity must notify the Contractor within 30 calendar days of the discovery.

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

(F) 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) of this attachment then the Contractor or the other entity shall conduct the required database searches and obtain the requisite written attestations. Thereafter the Contractor or the other entity shall conduct the monthly searches to ensure that any of those individuals or entities listed in Article 6.3.2(B) of this attachment have not been added to the databases. The party conducting the search shall keep records showing that these monthly searches are conducted.

(G) If the Contractor has developed an alternative method to screen for prohibited affiliations as described in Article 6.3 of this attachment, the Contractor shall send a written request to the Department describing the alternative method. The use of an alternative method must be approved by the Department, in writing.

(H) Wherever a search of the LEIE, SAM, or other federal database is required in this Contract, the Contractor may use other vetted databases that incorporate the SAM or LEIE database information and is not required to search these databases directly.

6.3.3 Reporting Prohibited Affiliations

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

(B) If the Contractor obtains a written prohibited affiliate attestation from an individual or entity stating that the individual or entity is an affiliate, as defined by FAR, of a person or entity that has been debarred, suspended, or otherwise excluded from participating in procurement activities under FAR 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 written attestation to the Department no later than 30 calendar days from the date the individual or entity provided the written attestation to the Contractor.

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

(1) shall notify the Secretary of HHS of the noncompliance.

(2) may continue the existing Contract with the Contractor unless the Secretary of HHS (in consultation with the HHS Inspector General) directs otherwise.

(3) may not renew or otherwise extend the duration of an existing contract with the Contractor unless the Secretary of HHS (in consultation with the HHS 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 Excluded Providers, Generally

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

6.4.2 Screening for Excluded Providers

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

(1) a certified Credentials Verification Organization (CVO) as long as the Contractor's written policies and procedures address selection of a CVO and that the Contractor may only use a CVO that:

(i) is certified by NCQA or other organization that offers a CVO certification program.

(ii) provides evidence of LEIE and SAM searches that include the dates of the searches.

(2) the NPDB as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on Exclusions.

(B) Before entering into an agreement 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 Excluded Providers.

(C) For providers that are Medicare-certified or are Medicaid providers, the Contractor need to search only for the provider's name (e.g., the name of a 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 determine that the Providers are not Excluded Providers and maintain documentation showing that such searches were conducted.

(E) Once the Contractor has credentialed the potential provider and enters into a Provider agreement, and the Provider is not Medicare-certified, the Contractor may delegate:

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

(2) searches of the Provider's providers who deliver Covered Services incident to the Provider's obligations under its agreement 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 Provider, the Contractor shall include this requirement in its written Provider agreement. The Contractor shall require the Provider to have written policies and procedures for conducting the delegated searches, for maintaining documentation that such searches were conducted, and for reporting any Exclusion findings to the Contractor within 30 calendar days of the discovery.

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

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

(J) Wherever a search of the LEIE, SAM, or other federal database is required in this Contract, the Contractor may use other vetted databases that incorporate the SAM or LEIE database information and is not required to search these databases directly.

6.4.3 Excluded Provider Payment Prohibition

If the Contractor employs or has an agreement 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 or Control Information

6.5.1 Disclosure Information

(A) The Contractor, pursuant to 42 CFR § 455.104, using the Department-specified form, shall provide disclosures of each Person with an Ownership or Control Interest in the Contractor.

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

(1) the person's name and address of any Person (individual or corporation) with an Ownership or Control Interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location and the P.O. Box address;

(2) date of birth and Social Security number (in the case of an individual);

(3) other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent or more interest;

(4) whether the Person (individual or corporation) with an Ownership or Control Interest in the Contractor is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling;

(5) whether the Person (individual or corporation) with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent or more interest is related to another person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling; and

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

(C) The Contractor shall, pursuant to 42 CFR § 455.104 and using the Department-specified form, provide disclosures of Managing Employees that include the name, address, date of birth, and Social Security number of any Managing Employee of the Contractor.

(D) Government-owned Entities

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

(E) Non-Profit Entities

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

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

(F) Officers/Directors - Corporations Only

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

(2) If the Contractor is organized as a corporation, the term director refers to members of the board of directors. In such instances, if the Contractor has a director of finance who is

not a member of the board of directors, the individual would not need to be disclosed as a director/board member. To the extent the individual meets the definition of a Managing Employee, the Contractor shall disclose the individual as a Managing Employee.

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

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

(5) The Contractor shall only disclose officers and directors of the Contractor. If the Contractor has indirect owner(s), the Contractor need not disclose the officers and directors of the indirect owner(s). If the indirect owner(s)' officers, directors or board members also serve as the Contractor's officers, directors or board members, then the Contractor shall disclose the indirect owner(s)'s officers, directors or board members in accordance with Article 6.5.1(A) of this attachment.

(6) Partners:

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

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

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

6.5.2 Reporting Timeframes

(A) The Contractor shall electronically submit the Department's MCE Disclosure Form:

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

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

(3) upon renewal or extension of the Contract;

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

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

(B) The Department shall review the ownership and control disclosure submitted by the Contractor and any of its Subcontractors as required in 42 CFR § 438.608(c).

6.5.3 Consequences for Failure to Provide Disclosures

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

6.6 Disclosure of Physician Incentive Plans

6.6.1 Disclosure of Physician Incentive Plans, Generally

The Contractor shall comply with the requirements set forth in 42 CFR § 422.208 and 42 CFR § 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 Covered Services furnished to any particular Enrollee. Indirect payments may include offerings of monetary value (such as stock offerings or waivers of debt) measured in the present or future.

6.6.3 Reporting Requirements

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

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

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

(2) the type of incentive arrangement (e.g., withhold, bonus, Capitation arrangement, etc.);

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

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

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

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

6.6.4 Substantial Financial Risk

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

6.6.5 Information to Enrollees

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

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

7.1 Service Authorization and Notice of Adverse Benefit Determination

7.1.1 Policies and Procedures for Service Authorization Requests

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

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

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

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

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

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

7.1.2 Timeframes and Procedures for Standard Service Authorizations

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

(1) The Contractor may extend the timeframe 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 timeframe for making standard Service Authorization decisions the Contractor shall:

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

(ii) inform the Enrollee of their 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 Timeframes and Procedures for Denying All or Part of a Service Authorization Request

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

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

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

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

(C) If the Contractor extends the timeframe for making standard Service Authorization decisions the Contractor shall:

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

(2) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

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

7.1.4 Timeframes and Procedures for Expedited Service Authorization Decisions

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

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

(2) may extend the 72-hour time period by up to 14 calendar days if:

(i) the Enrollee requests the extension; or

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

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

7.1.5 Service Authorization Decisions Not Reached within Required Timeframes

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

7.2 Other Adverse Benefit Determinations Requiring Notice of Adverse Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Failure to meet the performance standards found in Article 10.2.6 of this attachment constitutes an Adverse Benefit Determination. The Contractor shall provide a Notice of Adverse Benefit Determination to the Enrollee at the time either the Enrollee or Provider informs the Contractor that the Provider failed to meet the performance standards found in Article 10.2.6 of this attachment for waiting times.

7.2.4 Adverse Benefit Determination Due to Failure to Resolve Appeals and Grievances within Prescribed Timeframes

(A) Failure of the Contractor to act within the prescribed timeframes provided for resolving and giving resolution notice for Appeals and Grievances constitutes an Adverse Benefit Determination. The Contractor shall provide a Notice of Adverse Benefit Determination to

the Aggrieved Person at the time the Contractor determines the timeframe for resolving the Appeal or Grievance will not be met.

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

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

(D) If the Enrollee is not the Aggrieved Person, the Contractor shall provide the Notice of Adverse Benefit Determination to the Enrollee as well as to the Aggrieved Person.

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

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

7.3 Required Content of Notice of Adverse Benefit Determination

7.3.1 Required Content of Notice of Adverse Benefit Determination, Generally

(A) The Contractor's Notice of Adverse Benefit Determination to an Enrollee shall be in writing and meet the language and format requirements outlined in Article 3.6.3 of this attachment.

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

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

(2) the reason for the Adverse Benefit Determination;

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

(4) the right to request an Appeal of the Adverse Benefit Determination with the Contractor;

(5) the procedures for requesting an Appeal;

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

(7) the timeframe for filing an oral or written Appeal request, which is within 60 calendar days from the date on the Contractor's Notice of Adverse Benefit Determination; and

(8) that if the Adverse Benefit Determination is to reduce, suspend or terminate previously authorized services, the date the reduction, suspension or termination will become effective and:

(i) the Enrollee's right to request that services continue pending the outcome of an Appeal;

(ii) how to request that the services be continued;

(iii) that the Enrollee or the Enrollee's legal guardian or other authorized representative must request continuation of services;

(iv) the timeframe for requesting continuation of services, which is the later of the following: within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination, or by the intended effective date of the Contractor's proposed Adverse Benefit Determination;

(v) that if the Appeal decision is adverse to the Enrollee that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services; and

(vi) that if the Enrollee requests an Appeal and the Appeal decision is adverse to the Enrollee, the Enrollee has a right to request a State Fair Hearing.

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

(A) The Contractor shall develop and include as an attachment to the Notice of Adverse Benefit Determination an Appeal request form that an Aggrieved Person may use as the

written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Aggrieved Person chooses to submit a written request for an expedited Appeal, even though an oral request is all that is required. The form shall:

(1) include a mechanism for Aggrieved Persons to request an expedited Appeal (if they choose to submit a written expedited Appeal request);

(2) include a mechanism for the Enrollee, the Enrollee's legal guardian or other authorized representative to request continuation of services if the Adverse Benefit Determination is to reduce, suspend, or terminate previously authorized services; and include statements that:

(i) continuation of services must be requested within the later of the following: within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination, or by the intended effective date of the Contractor's proposed Adverse Benefit Determination, and if using this form to request an Appeal and continuation of services, that the form must be submitted within these timeframes; and

(ii) if continuation of services is requested and the Appeal decision is adverse to the Enrollee that the Enrollee may be required to pay for the continued services, to the extent that they were furnished solely because of the request for continuation of the services;

(3) summarize the assistance available to the Aggrieved Person to complete the Appeal request form and how to request the assistance; and

(4) include information on how the Appeal Request Form can be submitted promptly (email, fax, etc.).

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

Article 8: Grievance and Appeal System

8.1 Overall System

8.1.1 General Requirements

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

(1) a Grievance process whereby an Aggrieved Person may file a Grievance;

(2) an Appeal process whereby an Aggrieved Person may request an Appeal of an Adverse Benefit Determination; and

(3) procedures for an Aggrieved Person to access the State Fair Hearing system.

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

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

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

(1) provide that oral inquiries seeking an Appeal of an Adverse Benefit Determination are treated as an Appeal request; and

(2) include as parties to the Appeal:

(i) the Enrollee and the Enrollee's representative; or

(ii) the legal representative of a deceased Enrollee's estate.

8.3 Standard Appeal Process

8.3.1 Authority to File

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

8.3.2 Timing

The Aggrieved Person may request a standard Appeal, either orally or in writing, within 60 calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination.

8.3.3 Procedures

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

(B) The Contractor shall acknowledge, either orally or in writing, receipt of the standard Appeal request.

(C) The Contractor shall provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the standard Appeal.

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

(E) 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.

(F) The Contractor shall ensure that the individuals who make the decision on a standard Appeal are individuals who:

(1) were not involved in any previous level of review or decision-making nor a subordinate of any such individual;

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

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

(ii) a standard Appeal that involves clinical issues; and

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

8.3.4 Timeframes for Standard Appeal Resolution and Notification

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

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

(1) the Aggrieved Person requests the extension; or

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

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

(1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;

(2) give the Aggrieved Person written notice within two calendar days of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance if they disagree with that decision; and

(3) resolve the standard Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.3.5 Format and Content of Notice of Standard Appeal Resolution

The Contractor shall provide a written Notice of Appeal Resolution to the affected parties in accordance with format and language requirements found in Article 3.6.3 of this attachment. The written Notice of Appeal Resolution shall include:

(1) the results of the standard Appeal resolution process and the date it was completed;

(2) for standard Appeals not resolved wholly in favor of the Aggrieved Person, the following in the written Notice of Appeal Resolution:

(i) the right to request a State Fair Hearing and how to do so;

(ii) the right of the Enrollee or the Enrollee's legal guardian to request continuation of disputed services during the State Fair Hearing if the Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services;

(iii) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing;

(iv) the timeframe for requesting a State Fair Hearing when continuation of services is not requested as well as when continuation of services is requested; and

(v) a statement that if the State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services; and

(3) a copy of the Medicaid State Fair Hearing request form.

8.3.6 Continuation of Disputed Services During Standard Appeals

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

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

(2) the services were ordered by an authorized Provider;

(3) the period covered by the original authorization has not expired; and

(4) the Enrollee files a request for continuation of disputed services timely, which means filing on or before the later of the following:

(i) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or

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

8.3.7 Duration of Continued Disputed Services and Enrollee Responsibility

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

(1) the Aggrieved Person, the Enrollee's legal guardian, or other authorized representative withdraws the Appeal or State Fair Hearing request;

(2) the Aggrieved Person, the Enrollee's legal guardian, or other authorized representative fails to request a State Fair Hearing within 10 calendar days after the Contractor sends the notice of an adverse resolution;

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

(4) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person, the Enrollee's legal guardian, or other authorized representative.

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

8.3.8 Reversed Standard Appeal Decisions

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

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

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

8.4 Expedited Appeal Process

8.4.1 Process for Expedited Appeals

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

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

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

8.4.2 Authority to File

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

8.4.3 Timing

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

8.4.4 Procedures

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

(B) The Contractor shall ensure that punitive action is not taken against a Provider who either requests an expedited Appeal or supports an Aggrieved Person's Appeal request.

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

(D) The Contractor shall acknowledge receipt of the expedited Appeal request either orally or in writing.

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

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

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

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

(1) were not involved in any previous level of review or decision-making nor a subordinate of any such individual;

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

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

(ii) an expedited Appeal that involves clinical issues; and

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

8.4.5 Denial of a Request for an Expedited Appeal

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

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

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

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

8.4.6 Timeframes for Expedited Appeal Resolution and Notification

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

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

(1) the Aggrieved Person requests the extension; or

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

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

(1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;

(2) give the Aggrieved Person written notice within two calendar days of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance if they disagree with that decision; and

(3) resolve the expedited Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.4.7 Format and Content of Notice of Expedited Appeal Resolution

(A) The Contractor shall provide written Notice of Appeal Resolution and make reasonable efforts to provide oral notice of the resolution of an expedited Appeal.

(B) The Contractor shall provide a written Notice of Appeal Resolution to the affected parties in accordance with format and language requirements found in 42 CFR § 438.10. The written Notice of Appeal Resolution shall include:

(1) the results of the expedited Appeal resolution process and the date it was completed;

(2) for expedited Appeals not resolved wholly in favor of the Aggrieved Person, the Contractor shall include the following in the written Notice of Appeal Resolution:

(i) the right to request a State Fair Hearing and how to do so;

(ii) the right of the Enrollee or the Enrollee's legal guardian to request continuation of disputed services during the State Fair Hearing if the Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services;

(iii) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing;

(iv) the timeframe for requesting a State Fair Hearing when continuation of services not requested, as well as when continuation of services is requested; and

(v) a statement that if the State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services; and

(3) a copy of the Medicaid State Fair Hearing request form.

8.4.8 Continuation of Disputed Services During Expedited Appeals

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

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

(2) the services were ordered by an authorized Provider;

(3) the period covered by the original authorization has not expired; and

(4) the Enrollee files a request for continuation of disputed services timely, which means filing on or before the later of the following:

(i) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or

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

8.4.9 Duration of Disputed Services and Enrollee Responsibility

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

(1) the Aggrieved Person withdraws the Appeal or State Fair Hearing request;

(2) the Aggrieved Person fails to request a State Fair Hearing within 10 calendar days after the Contractor sends the notice of an adverse resolution;

(3) the Enrollee fails to submit to the State Fair Hearing office, within 10 calendar days after the Contractor sends the notice of an adverse resolution, a written request for continuation of the disputed services during the State Fair Hearing; or

(4) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person.

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

8.4.10 Reversed Expedited Appeal Decisions

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

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

8.5 State Fair Hearings

8.5.1 General Procedures

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

(B) If the Appeal decision is adverse, the Contractor shall provide notification to the Aggrieved Person that they may request a State Fair Hearing with the Department and shall give to the Aggrieved Person the Department's State Fair Hearing request form. The Contractor shall inform the Aggrieved Person that:

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

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

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

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

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

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

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

(1) bring witnesses;

(2) establish all pertinent facts and circumstances;

(3) present an argument without undue interference; and

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

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

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

(H) In accordance with 42 CFR § 431.244(f), the State Fair Hearing shall take final administrative action:

(1) within 90 calendar days of the earlier of:

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

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

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

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

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

8.6 Grievances

8.6.1 Authority to File a Grievance

The Aggrieved Person, the Enrollee's legal guardian, or other authorized representative may file a Grievance with the Contractor.

8.6.2 Timing

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

8.6.3 Procedures

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

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

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

(1) were not involved in any previous level of review or decision-making involving the Grievance nor a subordinate of any such individual;

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

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

(ii) a Grievance that involves clinical issues; and

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

8.6.4 Timeframes for Grievance Resolution and Notification

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

(B) For written Grievances, the Contractor shall notify the affected parties in writing of the disposition of the Grievance. For Grievances received orally, the Contractor shall notify the affected parties of the disposition either orally or in writing.

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

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

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

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

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

(1) the Enrollee requests the extension; or

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

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

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

(2) within two calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

8.7 Dispute Resolution, Reporting and Documentation

8.7.1 Reporting Requirements

The Contractor shall maintain complete records of all Appeals and Grievances and, on a quarterly basis, shall submit reports summarizing Appeals and Grievances using the Department-specified report forms. The Contractor shall separately track Grievances and Appeals that are relating to Children with Special Health Care Needs.

8.7.2 Document Maintenance, Appeals

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

(1) written Notices of Adverse Benefit Determination;

(2) date the Appeal request was received;

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

(4) a log of all oral Appeal requests including:

(i) date of the oral requests;

(ii) date of acknowledgement of oral requests for expedited Appeals and method of acknowledgment (orally or in writing);

(iii) a general description of the Appeal request; and

(iv) date of denials of requests for expedited Appeals;

(5) copies of written Appeal requests;

(6) copies of written notices of denial of requests for expedited Appeals;

(7) date of acknowledgement of written Appeal requests and method of acknowledgment (orally or in writing);

(8) copies of written notices when extending the timeframe for completing standard or expedited Appeals when the Contractor initiates the extension;

(9) date of each review, or if applicable, review meeting;

(10) the resolution, and date of resolution at each level of review, or if applicable, review meeting;

(11) name of the person conducting the Appeal;

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

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

8.7.3 Document Maintenance, Grievances

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

(1) the date the Grievance was received;

(2) a general description of the Grievance;

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

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

(5) the name of the person taking the Grievance;

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

(7) the date of each review, or if applicable, review meeting;

(8) the resolution, and date of resolution at each level of review, or if applicable, review meeting;

(9) the name of the person resolving the Grievance;

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

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

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

Article 9: Enrollee Rights and Protections

9.1 Written Information on Enrollee Rights and Protections

9.1.1 General Requirements

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

(B) The Contractor shall comply with any applicable federal and State laws that pertain to Enrollee rights and ensure that its employees and Network Providers observe and protect those rights.

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

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

9.1.2 Specific Enrollee Rights and Protections

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

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

(2) the right to be treated with respect and with due consideration for the Enrollee's dignity and privacy;

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

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

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

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

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

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

9.2 Network Provider-Enrollee Communications

9.2.1 General Requirements

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

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

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

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

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

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 General Requirements

(A) Subject to the information requirements in Article 9.3.1(A)(1) and Article 9.3.1(A)(2) of this attachment, if the Contractor that would otherwise be 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 attachment, is not required to do so if the Contractor objects to the service on moral or religious grounds. If the Contractor elects this option, the Contractor shall:

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

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

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

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

9.4 Advance Directives

9.4.1 General Requirements

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

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

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

Article 10: Contractor Assurances

10.1 General Assurances

10.1.1 Nondiscrimination

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

(1) ensure the Contractor complies with federal laws and regulations regarding nondiscrimination; and

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

10.1.2 Member Services Function

(A) The Contractor shall operate a Member Services function during Mountain Time regular business hours.

(B) As necessary, the Contractor shall provide ongoing training to ensure that the Member Services staff is conversant in the Contractor's policies and procedures as they relate to Enrollees.

(C) At a minimum, Member Services staff shall be responsible for:

(1) explaining the Contractor's rules for obtaining services;

(2) assisting Enrollees to select or change Primary Care Providers; and

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

(D) The Contractor shall conduct ongoing assessment of its orientation staff to determine staff members' understanding of the Contractor's Health Plan and its Medicaid managed care policies and provide training, as needed.

10.1.3 Provider Services Function

(A) The Contractor shall operate a Provider services function during Mountain Time regular business hours.

(B) At a minimum, Provider services staff shall be responsible for:

(1) training, including ongoing training, of the Contractor's Providers on Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;

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

(3) assisting Providers with Service Authorization Requests and referral protocols;

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

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

10.1.4 Contractor Licensure

(A) The Contractor shall be licensed with the Utah Department of Insurance. The Contractor shall maintain such licensure through the duration of the Contract and shall immediately

notify the Department in the event that its license is invalidated. The Contractor shall be exempt from this requirement if the Contractor:

(1) does not provide both inpatient hospital services and physician services;

(2) is a public entity;

(3) is (or is controlled by) one or more federally qualified health centers and meets solvency standards established by the State for those centers; or

(4) has its solvency guaranteed by the State.

10.1.5 Enrollee Liability

The Contractor shall not hold an Enrollee liable for:

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

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

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

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

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

10.2 Contractor Assurances Regarding Access

10.2.1 Documentation Requirements

(A) The Contractor shall provide the Department adequate assurances and supporting documentation that demonstrates the Contractor has the capacity to serve the expected enrollment in its Service Area with the Department's standards for access to care regarding appointment waiting times specified in Article 10.2.6 of this attachment.

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

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

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

(2) on an annual basis; or

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

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

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

(B) The Contractor shall furnish a quarterly report in a format specified by the Department that includes:

(1) how the Contractor identifies and tracks Enrollee access problems due to geographic, cultural and language barriers, and physical disabilities;

(2) the tools and methods the Contractor currently operationalizes to address this element of the contract;

(3) how the Contractor uses this information to reduce Enrollee access problems; and

(4) how the Contractor measures success in minimizing/eliminating an Enrollee's access problems.

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

(D) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, TTY/TDD, and other auxiliary aids and services to all Enrollees as needed at no cost.

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

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

10.2.3 Interpretive Services

(A) The Contractor shall make oral interpretive services available free of charge for all non-English languages, not just those the Department identifies as prevalent, on an as-needed basis. These requirements shall extend to both in-person and telephone communications, to

ensure that Enrollees are able to communicate with the Contractor and the Contractor's Network Providers and receive Covered Services.

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

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

(D) The Contractor shall cover interpretive services as described in the Utah Medicaid Provider Manual, and applicable MIB.

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

10.2.4 Cultural Competence Requirements

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

(B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollees' beliefs, being sensitive to cultural diversity, and promoting attitudes and interpersonal communication styles with staff and Network Providers that respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background, and beliefs.

(D) The Contractor shall strive to ensure its Network Providers provide culturally competent services to Enrollees. Contractor efforts shall include but are not limited to providing training to Network Providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to or provision of health care services.

10.2.5 No Restriction on Provider's Ability to Advise and Counsel

(A) The Contractor may not restrict a Provider's ability to advise and counsel Enrollees about Medically Necessary treatment options.

(B) All Providers acting within their scope of practice, shall be permitted to freely advise an Enrollee about their health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

10.2.6 Waiting Time Benchmarks

(A) The Contractor shall adopt benchmarks for waiting times for appointments as follows:

(1) Benchmarks for waiting times for appointments with a PCP are:

(i) within 30 calendar days for routine, non-urgent appointments;

(ii) within 30 calendar days for school physicals; and

(iii) within two calendar days for urgent, symptomatic, but not life-threatening care (care that can be treated in a Provider's office).

(2) Benchmarks for waiting times for appointments with a specialist (including behavioral health providers):

(i) within 30 calendar days for non-urgent care; and

(ii) within two calendar days for urgent, symptomatic, but not life-threatening care (care that can be treated in a specialist's office).

(B) These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

(C) The Contractor shall annually attest that waiting time benchmarks in Article 10.2.6 of this attachment have been met and specify the method for verification using a Department-specified format.

10.3 Coordination and Continuity of Care

10.3.1 General Requirements

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

(1) ensure that each Enrollee has an ongoing source of care appropriate to their 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; and

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

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

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

(iii) with the services the Enrollee receives through FFS when the services are carved-out of the Contract; 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 new Enrollee's needs within 90 calendar days of the effective date of enrollment and shall make subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful.

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

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

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

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

10.3.2 Primary Care

(A) The Contractor shall implement procedures to deliver Primary Care to and coordinate health care services for all Enrollees.

(B) The Contractor shall implement procedures to ensure that each Enrollee has an ongoing source of Primary Care appropriate to the Enrollee's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee. The Contractor shall provide the Enrollee information on how to contact the Enrollee's designated person or entity.

(C) The Contractor shall allow Enrollees the opportunity to select a participating PCP. This excludes Enrollees who are under the Restriction Program.

(D) If an Enrollee's Primary Care Provider ceases to participate in the Contractor's network, the Contractor shall offer the Enrollee the opportunity to select a new Primary Care Provider.

10.3.3 Rules for Enrollees with Special Health Care Needs

(A) The Department shall identify Enrollees with Special Health Care Needs. The Contractor shall have a mechanism in place to allow Enrollees with Special Health Care Needs to directly access a specialist.

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

10.3.4 Prepaid Mental Health Plan

(A) When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the Contractor and Prepaid Mental Health Plan shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

(B) The Contractor shall educate its Network Providers regarding an 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 a Prepaid Mental Health Plan, the Contractor shall not delay an Enrollee's access to needed services in disputes regarding responsibility for payment. Payment issues should be addressed only after needed services are rendered.

(D) Clients enrolled in the Health Plan and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, shall have access to such services in a timely fashion. The Contractor and Prepaid Mental Health Plan shall reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

10.4 Restriction Program

10.4.1 Restriction Program, Generally

(A) The Contractor shall have written policies and procedures describing how the Contractor shall operate the Restriction Program for their Enrollees. The policies and procedures shall be consistent with the requirements of this Contract and the Department's Administrative Rules. The Department shall retain the right to review and require changes to policies and procedures as needed.

(1) The Contractor shall submit Restriction policies and procedures to the Department annually, prior to the last day of the first month of each calendar year, and within five (5) business days of making substantive changes to those Restriction policies and procedures during that same calendar year.

(B) The Contractor shall be responsible for ensuring its Restriction staff members understand their responsibilities as described in all the Contractor's Restriction policies and procedures, including the Contractor's Restriction Interface use and shall provide any necessary training to their employees.

(C) The Contractor shall be responsible for surveillance and screening of its Enrollees to determine whether or not an Enrollee should be placed in the Restriction Program. The Contractor shall use the criteria in administrative code R414-29 to determine if an Enrollee should be placed in the Restriction Program.

(D) The Contractor shall maintain documentation for each Enrollee reviewed for, placed in or removed from the Restriction Program.

(E) When it is determined that an Enrollee is to be placed in the Restriction Program, the Contractor shall place the Enrollee in the Restriction Program for 12 months of Medicaid eligibility.

(F) If a Restricted Enrollee has been in the Restriction Program for less than 12 months, becomes ineligible for Medicaid, and subsequently becomes an Enrollee again within 12 months of having become ineligible, the Contractor shall reenroll the Enrollee in the Restriction Program for the remainder of the original 12-month Restriction Program period.

(G) If a Restricted Enrollee becomes ineligible for Medicaid for more than 12 months and later becomes an Enrollee, the Contractor shall not automatically place the Enrollee in the Restriction Program.

(H) The Department may periodically conduct an audit of the Contractor's Restriction Program. If the Contractor's documentation does not support the criteria for placing an Enrollee in the Restriction Program, the Department may overturn the Contractor's decision to place the Enrollee in the Restriction Program. In the event that the Contractor's determination to place an Enrollee in the Restriction Program is found to be incorrect, the Department shall recoup the Restriction Program Capitation Payment from the date the Enrollee was placed in the Restriction Program and pay the Contractor the appropriate Capitation Rate.

10.4.2 Notice Requirements

(A) Before placing an Enrollee in the Restriction Program, the Contractor shall give an Enrollee written notice at least ten days prior to placing the Enrollee in the Restriction Program. The notice shall contain the following information:

(1) the reason why the Enrollee is being placed in the Restriction Program;

(2) the Restriction Program criteria/criterion which the Enrollee has met;

(3) the length of enrollment in the Restriction Program which is at a minimum 12 months of the most recent continuous Medicaid eligibility;

(4) the Enrollee's right to submit an Appeal to the Contractor, if the Enrollee disagrees with the Contractor's determination;

(5) the timeframe in which the Enrollee must submit the Appeal;

(6) a description of the Restriction Program, including that the Enrollee will be assigned a Restriction PCP, Restriction Pharmacy and all approved Providers through which the Enrollee's care will be directed; and

(7) the Enrollee's right to choose a Restriction PCP and Restriction Pharmacy within 30 days of the date of notification.

(B) As stated in Article 8.5 of this attachment, once an Enrollee has exhausted the Contractor's internal Appeal process, the Contractor shall inform the Enrollee of their right to a state fair hearing with the Department and the timeframe in which the Enrollee must file a request for a state fair hearing, including appropriate forms, instructions, and information significant to request an administrative hearing. The Contractor shall appear at the administrative hearing and defend the Enrollee's placement in the Restriction Program. The Contractor shall provide verbal guidance and assistance with the appeal process, up to and including providing the Restriction member assistance with filling out and submitting the appropriate form(s).

(C) Prior to placing an Enrollee in the Restriction Program, the Contractor shall:

(1) Provide the Enrollee with an opportunity to participate in the identification of a Restriction PCP and Restriction Pharmacy. If the Contractor approves of the Enrollee's choice of Restriction PCP, the Contractor shall ensure that the chosen Restriction PCP agrees to serve as the Restriction PCP for the Restriction Program Enrollee and document such agreement on one of the Standardized Review Templates (ORSRT or the SRSRT);

(2) Identify, with the approval of the Restriction PCP, additional prescribers and providers approved to prescribe medications and approved to provide specialty medical services respectively to the Restricted Enrollee;

(3) Submit the assigned Restriction PCP, approved Restriction prescribers/providers and Restriction Pharmacy to the Department using the Contractor's Restriction Interface. Submission to the Department of Primary PCP and Primary Pharmacy, shall be provided to the Department through the Contractor's Restriction Interface prior to 10-day notice as per 42 CFR § 435.919 and Benefit Issuance of the month proceeding the begin date of the Restriction PCP and Restriction Pharmacy; and

(4) Do the following if the Enrollee cannot be contacted to offer an opportunity to choose a Restriction PCP:

(i) identify a Restriction PCP whose practice is proximal to the Enrollee's residential address of record and/or recently familiar with the Enrollee's medical history;

(ii) obtain consent from the identified Restriction PCP to act in the capacity of Enrollee's Restriction PCP;

(iii) identify, with the approval of the Restriction PCP, Restriction additional prescribers and providers allowed to prescribe medications and provide specialty medical services respectively to the Restriction Enrollee;

(iv) identify a Restriction Pharmacy that is proximal to the Enrollee's residential address and/or primarily used by the Enrollee to obtain prescription medications;

(v) notify the Department using the Contractor's Restriction Interface prior to 10-day notice as per 42 CFR § 435.919 and Benefit Issuance of the month proceeding the begin date of the Restriction PCP;

(vi) allow the Restriction Enrollee to choose a different Restriction PCP within 30 days after enrollment in the Restriction Program. If the Enrollee's choice of PCP agrees to serve in the capacity of Restriction PCP, and if the Contractor accepts the PCP as a Restriction PCP, the Contractor shall notify the Department through the Contractor's Restriction Interface in one business day, but no later than three business days of the change of PCP and any changes of Restriction prescribers approved by the new PCP; and

(vii) submit to the Department (concurrently with the notification of the start date of the new Restriction PCP, using the Contractor's Restriction Interface of the end date of the original Restriction PCP and any Restriction additional prescribers/providers approved by the original Restriction PCP.

(D) The Contractor shall notify the Restricted Enrollee of the Restriction PCP, who will remain the Restriction PCP during the duration of the Restricted Enrollee's placement in the Restriction Program, unless good cause is shown in accordance with Utah Administrative Code R414-29.

(E) The Contractor shall provide written notification to the Restricted Enrollee of discharge from the Restriction Program prior to the Benefit Issuance Date in the month the discharge occurs.

10.4.3 Coordination with the Department

(A) The Contractor shall provide to the Department, utilizing the Contractor's Restriction Interface, information regarding an Enrollee who the Contractor has determined to be eligible for the Restriction Program. The information submitted using the Contractor's Restriction Interface shall include:

(1) the name and NPI of the Restriction PCP who has agreed to serve as the Restricted Enrollee's designated Restriction PCP;

(2) the date on which the Provider agreed to serve as the Restricted Enrollee's designated Restriction PCP;

(3) the name and NPI of the designated Restriction Pharmacy;

(4) the name and NPI of any additional Providers/prescribers approved by the Restriction PCP once the Restriction PCP has agreed to be the Restriction PCP; and

(5) the date on which enrollment in the Restriction Program will commence.

(B) The Contractor shall respond to messages sent by the Department through the Restriction Electronic Messaging System within three (3) business days of receipt of the message.

(C) The Department shall respond to messages sent by the Contractor through the Restriction Electronic Messaging System within three (3) business days of receipt of the message.

(D) The Contractor shall make requests telephonically of the Department when a response or action is deemed immediately necessary.

(E) The Contractor shall notify the Department in one business day, but no later than three business days of adding a Restriction PCP, a Restriction Pharmacy, or a Restriction prescriber to their system using the Contractor's Restriction Interface.

(F) The Contractor shall end date, through the Contractor's Restriction Interface, Restriction PCPs, Restriction Pharmacies, and Restriction secondary prescribers who are no longer actively engaged in the care of the Restricted Enrollee or approved by the Restriction PCP in one business day, but no later than three business days of the decision to create the end date.

(G) The Contractor may enroll an Enrollee in the Restriction Program, after 10 day notice to the member as required by 42 CFR § 431.211 and prior to the Benefit Issuance Date in the Contractor's Pharmacy Benefit Management System. However, in the event the Enrollee submits a Grievance or requests pre-hearing and the Grievance, pre-hearing or hearing is

found in favor of the Enrollee, the Contractor shall pay all Claims that were denied due to the Restriction enrollment status of the Enrollee.

(H) If the Department receives the submission of a Restriction start date through the Contractor's Restriction Interface prior to the Benefit Issuance Date, the Contractor shall receive the Restriction Capitation Rate the next month. If the Department receives the Restriction start and end date through the Contractor's Restriction Interface after the Benefit Issuance Date, the Contractor shall receive the Restriction Capitation Rate the month following the next month.

(I) The Contractor understands and agrees that the payment of the Restriction Program Capitation Rate will occur the month the Restricted Enrollee is placed in the Restriction Program.

10.4.4 Restriction Program Criteria

(A) As stated in Article 10.4.1(C) of this attachment, the Contractor shall use the criteria in administrative code R414-29 to determine if an Enrollee should be placed in the Restriction Program.

(B) The Contractor shall also take into consideration the following when determining whether to place an Enrollee in the Restriction Program:

(1) the Enrollee's diagnoses and Medical Necessity;

(2) the Enrollee's concurrent prescribers of Abuse Potential Medications;

(3) the Enrollee's geographic location and potential of limited access to care in rural areas; and

(4) the Enrollee's right to seek a second opinion.

(C) The Contractor shall not place an Enrollee in the Restriction Program when Restriction criteria, as outlined in Article 10.4.4 of this attachment, is found to be met as a function of, or is attributed to limited access to care and/or Medical Necessity or the member has utilized the right to seek a second opinion. Such attributes shall be clearly documented in the Department approved ORSRT or SRSRT.

10.4.5 Management of the Enrollee's Restriction

(A) The Contractor shall complete the annual review prior to benefit issuance in the 12th month of the Enrollee's Restriction and submit the decision using the Contractor's Restriction Interface to the Department before Benefit Issuance of the 12th month of Restriction Enrollment and prior to the 13th month of Restriction. If the decision is to terminate enrollment in the Restriction Program, the enrollment in the Restriction Program shall be end dated as of the last day of the 12th month of Restriction enrollment.

(B) If the Contractor determines the Restricted Enrollee no longer meets Restriction Program criteria, the Contractor shall remove the Enrollee from the Restriction Program. At the end of the Restricted Enrollee's 12-month Restriction Program enrollment, the Department shall discontinue payment of the Restriction Program Capitation Rate and pay the Capitation Rate for which the Enrollee would otherwise be eligible.

(C) If the Contractor determines the Restricted Enrollee continues to meet Restriction Program criteria, the Contractor shall continue enrollment of the Restricted Enrollee in the Restriction Program and notify the Department through the Restriction Electronic Messaging System within three business days of the determination.

(D) The Contractor shall document the activities the Contractor intends to provide to each Restricted Enrollee during the upcoming Restriction period. Such documentation shall be made available to the Department using the Department ORSRT or SRORT corresponding to the continued Restriction Review and decision documentation that is submitted to the Department.

(E) The Contractor shall place an Enrollee in the Restriction Program upon written request from the Department based on criteria.

(F) The Contractor shall remove a Restricted Enrollee from the Contractor's Restriction Program upon written request from the Department. If the Contractor disagrees with a written request to remove a Restricted Enrollee from its Restriction Program, the Contractor may submit a written appeal, which must be received within ten (10) business days, to the Division's Medical Director detailing how the enrollee meets Restriction criteria.

(G) The Contractor shall provide timely and efficient case management for the Enrollee by, at a minimum:

(1) utilizing techniques allowing for case management independent of the Department; and

(2) resolving Enrollee's carved-out pharmacy and prescription inquiries or complaints, independent of the Department, by consulting with member's assigned pharmacy and prescribers for issues such as, but not limited to "Prior Authorization Needed," "Refill too Soon," "Exceeds Plan Limits," "Bill 30-Day Supply" rejections.

10.4.6 Enrollees Exempt from Restriction

The Contractor shall not place an Enrollee in the Restriction Program when the Enrollee is dually eligible and enrolled in Medicare and Medicaid, or receives Veterans Affairs benefits.

10.4.7 Restriction Program Management

(A) The Contractor shall provide care coordination for its Restricted Enrollees. The Contractor shall document all case/care management activities provided to Restricted Enrollees.

(B) The Contractor shall have a contact person that Restricted Enrollees or providers may contact for care coordination or case management. The Contractor shall provide this contact information to the Restricted Enrollee 10 business days prior to their enrollment in the Restriction Program. The Contractor shall maintain a telephone line that the Restricted Enrollees or providers may contact for care coordination and questions. The telephone line shall be available between 8:00 AM and 5:00 PM (Mountain) Monday through Friday with the exception of State and federal holidays. The telephone line shall have sufficient coverage to ensure calls are answered within two (2) minutes by a live representative. Phone messages received after-hours, holidays or weekends shall be responded to within one business day.

(C) The Contractor shall provide the following Restriction Program services:

(1) initial orientations about the Restriction Program and ongoing education on the appropriate use of medical services;

(2) Medically Necessary services, including urgent care and emergent care; and

(3) care coordination and Restriction plans developed by the Contractor and the Restricted Enrollee's Restriction PCP. Such plans shall be made available to the Department within five (5) business days of request.

(D) The Contractor shall notify a Provider serving as a Restricted Enrollee's Restriction PCP of their responsibilities and shall submit documentation of that notification to the Department within five (5) business days of request.

(E) The Contractor shall ensure the designated Restriction PCP agrees to:

(1) manage all of the Restricted Enrollee's medical care;

(2) educate the Restricted Enrollee regarding the appropriate use of medical services;

(3) provide a referral to another Provider when needed care is not within the Restriction PCP's field of expertise, or when, for some other reason, the care cannot be provided by the Restriction PCP;

(4) be telephonically available 24 hours a day, seven days a week through a nurse hotline or other similar communication method, (or make certain a Provider of comparable specialty is available) for urgent/emergent medical situations to assure the availability of prompt, quality, medical services and continuity of care;

(5) manage acute and/or chronic long-term pain through a variety of services or treatment options including, referral to a pain management specialist, office calls, medication administration, physical therapy, counseling and mental health referral with emphasis on teaching Restricted Enrollees to manage their pain by adapting actions and behaviors, as applicable;

(6) approve or deny drugs prescribed by other Providers when contacted by the Restriction Pharmacy to which the Restricted Enrollee is assigned; and

(7) work with pharmacy, specialists, dentists, behavioral health Providers, etc. to share pertinent information regarding the Restricted Enrollee.

(F) If the Restricted Enrollee's Restriction PCP chooses to no longer serve as the Restricted Enrollee's Restriction PCP, the Contractor shall designate a new Restriction PCP to the Restricted Enrollee within 30 days. The Contractor shall maintain the existing Restriction PCP until a replacement Restriction PCP is designated.

(G) The Contractor shall ensure the Restricted Enrollee has any required medication to ensure a continuity of care during a transition from the current Restriction PCP to a new Restriction PCP.

(H) If a Restricted Enrollee becomes eligible for FFS, the Contractor shall coordinate with the Department to ensure continuity of care for the Restricted Enrollee.

(I) If the Contractor fails to follow the policies and procedures found in Article 10.4 of this attachment, the Department shall pay the Contractor the amount of the corresponding non-Restriction Program rate cell for the Enrollee.

(J) If a Restricted Enrollee transfers:

(1) from FFS to the Contractor, the Department shall coordinate with the Contractor to ensure all necessary information is obtained to continue the Restriction Program and properly manage the Restricted Enrollee's care (including but not limited to designated physicians and pharmacies). The Contractor shall utilize Department provided look-up tools to assess current approved providers. The Contractor may request prior Restriction review information as needed from the Department; and

(2) from another MCO to the Contractor, the Contractor shall coordinate with the other MCO to ensure all necessary information is obtained to continue the Restriction Program and properly manage the Restricted Enrollee's care (including but not limited to designated physicians and pharmacies).

(K) If there is a change in a Restricted Enrollee's Restriction PCP, Restriction Pharmacy, or other Restriction Providers or prescribers, the Contractor shall notify the Department through

the Contractor's Restriction Interface in one business day, but no later than three business days of the change.

(L) Pursuant to 42 CFR § 431.54(e) (3) and Article 4.3.1(E) of this attachment, a Restricted Enrollee may receive emergency services from any Network Provider or Non-Network Provider.

10.4.8 Restriction Program Reports

(A) The Contractor shall maintain the SRSRT and email it to the medicaidrestriction@utah.gov on the first business day following the 1st and 15th of each month for the reviews completed since the previous submission.

(B) To assist in auditing a Contractor's review or to assist in a hearing, the Contractor shall make an ORSRT available to the Department within five (5) business days of a request

(C) No later than ten (10) business days after the end of each quarter, using the Department's template, the Contractor shall report to the Department the following information for the immediately preceding quarter:

(1) the monthly number of Enrollees the Contractor's surveillance tools indicated potentially met Restriction Program criteria;

(2) the monthly number of Enrollees reviewed for potential placement in the Restriction Program in accordance with Article 10.4.4(C) of this attachment;

(3) the monthly number of Enrollees added to the Restriction Program;

(4) the monthly number of Restricted Enrollees discharged from the Restriction Program as a result of their annual review;

(5) the monthly number of Restricted Enrollees reviewed, but not discharged from the Restriction Program, and an explanation of specifically planned efforts for each member to reduce utilization during the coming 12 months of Medicaid eligibility;

(6) the numbers of Staff performing reviews;

(7) the numbers of Staff performing case management of Restricted Members;

(8) the average call wait time, and the number of callers who waited more than two minutes to speak with a live representative; and

(9) whether all annual reviews due in the reporting quarter were done in accordance with Section 10.4.5(A).

(D) The Contractor shall submit an annual Restriction Program staffing plan on November 1 of each year.

(E) The Contractor shall use the SRSRT for each member reviewed. The Department will give a 30 day notice for substantive changes to the SRSRT. For other changes, the Department will give a five (5) business day notice.

(F) The Contractor shall make all records and documentation pertaining to the Contractor's Restriction Program available to the Department within five (5) business day of request.

(G) All reports and requests for information shall be emailed to MedicaidRestriction@utah.gov.

10.5 Billing Enrollees

10.5.1 Enrollee Billing, Generally

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

10.5.2 Circumstances in Which an Enrollee May Be Billed

(A) An Enrollee may be billed for:

(1) Services not covered under the Contract and not covered by Medicaid; or

(2) Services covered under the Contract but not authorized by the Contractor.

(B) An Enrollee may be billed only when:

(1) the Provider has an established policy for billing all patients for services not covered by a Third Party (i.e., the charge cannot be billed only to Medicaid Members);

(2) the Provider has informed the Enrollee of its policy for billing patients for services described in (A)(1) and (A)(2) above;

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

(4) prior to rendering the service, a written agreement is signed by the Enrollee and the Provider that details the service and the amount to be paid by the Enrollee.

(C) For services covered by Medicaid but not covered under the Contract (carved out services), the Provider must follow the Department's FFS policy for billing and shall not bill the Enrollee for Medicaid-covered services.

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

10.5.3 Prohibition on Holding Enrollee's Medicaid Card

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

10.5.4 Medical Cards, Generally

If the Contractor elects to provide its own medical cards for Enrollees, the Contractor and its Network Providers may not require the Enrollee to present their Contractor-printed medical card at the time of service. The only card that the Contractor may require is the Medicaid card issued by the Department.

10.5.5 Criminal Penalties

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

10.6 EPSDT Requirements

10.6.1 General EPSDT Requirements

The Contractor shall provide to EPSDT Enrollees Medically Necessary Covered Services and all other services required under 42 USC 1396d(r), and shall have a process in place through which EPSDT Enrollees may request these services.

Article 11: Payments

11.1 General Payment Provisions

11.1.1 Comprehensive Risk Contract

This Contract is a Comprehensive Risk Contract.

11.1.2 Payment Methodology

The payment methodology is described in Attachment E.

11.1.3 Contract Maximum

In no event shall the aggregate amount of payments to the Contractor exceed the Contract maximum amount. If payments to the Contractor approach or exceed the Contract amount before the renewal date of the Contract, the Department shall make a good faith effort to execute a

Contract amendment to increase the Contract amount within 30 calendar days of the date the Contract amount is exceeded.

11.1.4 Payment Recoupment

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

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

11.1.5 Overpayments

(A) The Contractor shall have written policies and procedures that specify:

(1) that the Contractor shall report to the Department within 60 calendar days when it or any Subcontractor has identified Capitation Payments or other payments in excess of amounts specified in the Contract;

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

(3) the process, timeframes, and documentation required for reporting to the Department the recovery of Overpayments; and

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

(B) The Contractor shall have and use a mechanism for a 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 a quarterly report of Overpayments and recoveries within the timeframes specified by the Department. The report shall be in a Department-specified format. The Contractor shall also submit copies of the reports to the Utah OIG (mpi-@utah.gov) of Fraud, Waste, or Abuse-related Overpayments.

11.1.6 Recovery and Retention of Overpayments, Generally

The Contractor may collect and retain Overpayments from Providers. If Overpayments are related to Fraud, Waste, or Abuse, then Article 11.1.7 and Article 11.1.8 of this attachment apply.

11.1.7 Collection and Retention of Overpayments Related to Fraud, Waste, or Abuse

The Contractor may collect and retain Overpayments it recovers during the Recovery Period.

11.1.8 Referral to the Utah OIG of Overpayments Related to Fraud, Waste, or Abuse

(A) When the 12 months of the Recovery Period have ended and the Contractor has not recovered any Overpayments from the Provider, or has ceased collecting Overpayments from the Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(B) If the Contractor has been collecting Overpayments from the Provider during the 12 months of the Recovery Period, the Contractor may continue to recover Overpayments from the Provider after the 12 months of the Recovery Period. If at any time after the twelfth month of the Recovery Period the Contractor determines it will be unable to continue collection, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(C) If the Contractor chooses not to pursue any Overpayment recoveries from a Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Utah OIG will retain its Overpayment recoveries.

(D) If the Utah OIG identifies an unreported Overpayment, the Utah OIG will coordinate with the Contractor and may pursue collection of the Overpayment. The Utah OIG will retain its Overpayment recoveries.

(E) The Contractor shall correct Encounter Data related to Overpayments in accordance with Article 12.4.1 of this attachment.

11.1.9 Program or Activity No Longer Authorized by Law

Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer

authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the Capitation Payment for that work should be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its Capitation Payments to the Contractor, the Contractor may keep the Capitation Payment for that work even if the payment was made after the date the program or activity lost legal authority.

11.2 Medicare

11.2.1 Payment of Medicare Part B Premiums

(A) The Department shall pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee shall assign to the Contractor their Medicare reimbursement for benefits received under Medicare.

(B) The Department shall identify on the Eligibility Transmission the Enrollees who are covered under Medicare.

11.2.2 Payment of Services Covered by Medicare

(A) The Contractor's payment for Medicare Crossover Claims shall be the allowed amount of Contractor's payment rate less any amounts paid by Medicare and other payers.

(B) When a service is paid for by Medicare, unless (C) below applies, the Contractor shall pay in accordance with 11.2.2(A) of this Contract when the provider is a Medicaid provider and whether or not:

(1) the service is covered under this Contract; or.

(2) the Medicare-covered service is rendered by a Network Provider or has been authorized by the Contractor.

(C) The Contractor is not responsible to pay Crossover Claims with a primary diagnosis of a Behavioral Health Condition unless the crossover Claim is for Emergency Department services, including Emergency Department evaluation and management (E/M) services.

11.2.3 Prohibition on Balance Billing

The Contractor shall ensure its Network Providers will not Balance Bill the Enrollee. The reimbursement from the Contractor, plus copayments, deductibles and/or coinsurance shall be payment in full.

11.2.4 Coordination of Benefits for Dual Eligibles

To the extent that 42 CFR § 438.3(t) applies, the Contractor shall enter into a Coordination of Benefits Agreement with Medicare.

11.3 Third Party Liability and Coordination of Benefits

11.3.1 Recovery of Third Party Liability, Generally

(A) The Contractor shall make reasonable efforts to pursue the recovery of TPL for Covered Services provided to Enrollees. To assist the Contractor, the Department shall include on the Enrollee Eligibility Transmission other known Third Parties available to each Enrollee.

(B) In the event that the Contractor collects TPL on a Claim after the Encounter Data has been submitted to the Department, the Contractor shall submit corrected Encounter Data to accurately reflect the TPL collection.

11.3.2 Policies and Procedures for Third Party Liability Recovery

The Contractor shall develop policies and procedures describing how it will conduct TPL recovery. Such policies and procedures shall be consistent with the requirements of 42 U.S.C. § 1396(A)(25) and 42 CFR § 433 subpart D. The policies and procedures shall contain:

(1) procedures and mechanisms to identify potentially liable Third Parties. Procedures and mechanisms shall include, at a minimum, verification of any Third Party coverage at the time of service. When Enrollees obtain Covered Services from Providers not employed by the Contractor, the Contractor may delegate the Third Party verifications to Providers;

(2) procedures and mechanisms to identify the amount owed by a Third Party;

(3) procedures and mechanisms for recovery of Third Party payments; and

(4) procedures and mechanisms to report to the ORS any Third Party discrepancies identified within 30 business days of receipt of the Eligibility Transmission. The Contractor's report shall include a listing of Enrollees that the Contractor has independently identified as having another Third Party, including when an Enrollee's parent has an order of duty to provide medical support. The Contractor shall report changes to ORS either by email (TPLChanges@utah.gov) or by fax (801-536-8912).

11.3.3 Cost Avoidance and Pay and Chase

(A) The Contractor shall use reasonable efforts to evaluate the probable existence of TPL. Probable existence of TPL exists where:

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

(2) the Contractor or Provider has determined that the Third Party will likely cover the service.

(B) Except as otherwise provided in Article 11.3.3(C) of this attachment, if the Contractor has established the probable existence of TPL, the Contractor shall, if providing services directly, seek payment from the Third Party, or at the time a Provider files a Claim with the Contractor, the Contractor must reject the Claim and return it to the Provider for a determination of the amount of liability.

(1) The establishment of TPL takes place when the Contractor receives confirmation from the Provider or a Third Party resource indicating the extent of TPL.

(2) In accordance with 42 CFR § 433.139, when the amount of liability is determined, the Contractor shall pay the Provider the lesser of the Medicaid fee schedule and the contracted amount between the Third Party and the Provider.

(C) In the following situations, the Contractor must pay the Provider's Claim first and then seek reimbursement from the liable Third Party if:

(1) the Claim is for an EPSDT Enrollee (including preventative pediatric services), and is covered under the State Plan; or

(2) the Claim is for a service covered under the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the state IV-D agency. In this instance the Contractor shall pay the Provider if the Provider has certified to Contractor the provider has billed a Third Party, and the Provider has waited 100 days from the date of the service and has not received payment from the Third Party.

(D) If the probable existence of TPL cannot be established or Third Party benefits are not available to pay the Enrollee's medical expenses at the time a Claim is filed by a Network Provider, the Contractor must pay the full amount allowed under the Contractor's payment schedule, or at the time a Claim is filed by a Non-Network Provider that has a payment agreement with the Contractor, the Contractor must pay the pre-negotiated rate.

(E) If the Contractor or Provider learns of the existence of a liable Third Party after the Contractor has provided a service or after a Provider's Claim is paid, or benefits become available from a Third Party after the Contractor has provided a service or has paid a Claim, the Contractor or Provider, as applicable, must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable Third Party or benefits become available. If the Provider obtains the payment from the Third Party, the Contractor shall recoup the payment from the Provider.

(F) The Contractor shall retain any payment it receives from TPL. Unless Article 11.3.3(E) of this attachment applies, the Provider shall retain any payment it receives stemming from TPL.

(G) Recovery is not required when a Claim is $100 or less or $300 or less for cumulative Claims.

(H) The Contractor shall report TPL payments in the Encounter Data that are submitted to the Department.

11.3.4 Third Party Liability and Access to Care

(A) The Contractor shall not require an Enrollee to obtain Covered Services from a Provider solely on the basis that the Provider is on the Third Party's provider panel.

(B) The Contractor shall pay Claims for Covered Services obtained by an Enrollee from a Provider when the Provider is not on the Third Party's provider panel and the Contractor has determined that the Enrollee should receive Covered Services from the Provider to ensure access to appropriate care.

11.4 Personal Injury Cases

11.4.1 Notification of Personal Injury Cases

(A) The Contractor shall be responsible to notify ORS of all potential personal injury cases.

(B) Once a month, the Contractor shall submit to ORS a file of Claims which includes personal injury diagnosis codes. The file shall be in a format required by ORS.

11.4.2 Request for Assignment

(A) The Contractor may request from the Department an assignment of the Department’s right of recovery for an Enrollee who has a Claim against a Third Party for an injury, disease or disability if:

(1) the Enrollee has not filed a Claim or commenced an action for recovery or the Enrollee has not commenced an action pro se;

(2) the Enrollee does not have FFS Claims, PMHP Claims, or Claims from another Health Plan which would be included in the action for recovery; and

(3) ORS has not already commenced an action for recovery.

(B) The Department may grant an assignment to the Contractor in accordance with Article 11.4.2(A) of this attachment at its sole discretion. Any grant of an assignment shall be in writing. If the Department grants the assignment:

(1) the Contractor shall be required to update the Department with the status of the Contractor's recovery efforts upon request of the Department;

(2) the Contractor shall bear its own costs associated with the recovery;

(3) the Contractor shall report any TPL Recoveries on the 837 File;

(4) the Contractor shall be responsible for conducting any defense associated with any challenge of the assignment as well as costs associated with such defense; and

(5) any amounts recovered by the Contractor shall be retained by the Contractor.

(C) In any action commenced by ORS to pursue recovery of medical costs pursuant to Utah Code Ann. §26-19-7, the amounts recovered by ORS shall be retained by the Department.

11.5 Contractor's Payment Responsibilities

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

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

(1) Emergency Services;

(2) court ordered services that are Covered Services defined in Attachment C;

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

(4) Covered Services which an Enrollee has obtained from a Non-Network Provider for purposes of utilizing the Enrollee's TPL.

11.5.2 Payment to Non-Network Providers

The Contractor shall reimburse Non-Network Providers for Emergency Services, and unless there is a negotiated arrangement, payment shall not exceed the lower of the following rates applicable at the time the services were rendered to an Enrollee:

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

(2) the rate equal to the applicable Medicaid FFS rate; or

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

11.5.3 Payment of Covered Services Due to Retroactive Coverage Due to Change in Program Type

If a Medicaid Member was enrolled in a different MCE and their eligibility program type is changed retroactively to another eligibility program type and is then retroactively enrolled with the Contractor, the Contractor shall be responsible to reimburse Providers for Covered Services provided in the retroactive period and shall not impose Service Authorization requirements. This provision does not prohibit the Contractor from validating Medical Necessity for ongoing or future services.

11.5.4 Covered Services that are Not the Contractor's Responsibility

(A) The Contractor may not restrict an Enrollee's choice of Provider for family planning services and supplies. The Contractor is not responsible for payment when family planning services are obtained by an Enrollee from a Non-Network Provider.

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

(C) An Enrollee who is Indian may choose to seek Covered Services from an Indian Health Care Provider. The Contractor shall not be required to pay for Covered Services provided to Indian Enrollees who receive services provided by Indian Health Care Providers. Such services shall be paid by the Department.

11.5.5 Department Responsibility for Payment

Except as described in Attachment E or otherwise by this Contract, the Department shall not be required to pay for any Covered Services under Attachment C which the Enrollee receives from any source outside of the Contractor except for family planning services.

11.5.6 Administrative Fee for Immunizations

When an Enrollee under the age of 19 has Third Party coverage for immunizations, the Contractor shall pay the Provider the administrative fee for providing the immunization and not require the Provider to bill the Third Party. The Contractor may choose to pursue the Third Party for the administrative fee after the payment has been made to the Provider.

11.5.7 Payment for Services to Newborns

If a baby is born to an Enrollee, the Contractor is responsible for all inpatient facility and inpatient professional services for both the mother and the newborn Enrollee associated with the birth.

11.6 Enrollee Transitions between Managed Care Entities or Fee for Service

11.6.1 Transition of Care Policy

The Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the Department-defined transition of care policy described in Article 11.6 of this attachment.

11.6.2 Transitions During Inpatient Hospital Stays

(A) When an Enrollee is in an inpatient hospital setting and becomes enrolled in a different MCE or FFS 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) The Contractor shall not be responsible for an inpatient hospital stay when a Medicaid Member is not an Enrollee at the time of admission to the hospital and becomes an Enrollee during the hospital stay. The entity in which the Medicaid Member was enrolled at admission to the hospital is responsible for the entire hospital stay, including all services related to the stay until the patient is discharged.

(C) When an Enrollee is in an inpatient hospital setting and becomes ineligible for Medicaid any time prior to discharge from the hospital, the Contractor is financially responsible for the inpatient hospital stay only for the period of Medicaid eligibility.

(D) When an Enrollee in an inpatient hospital setting loses eligibility and then later becomes eligible retroactively for Medicaid, without a break in Medicaid coverage, then the Contractor is financially responsible for the inpatient hospital stay.

(E) If an Enrollee is no longer Medicaid-eligible due to incarceration and is admitted for an inpatient hospital stay during the incarceration period, the Contractor is not financially responsible for the inpatient hospital stay.

11.6.3 Enrollee Transition, Home Health Services

(A) When Enrollees have been in FFS or have been enrolled in a different MCE and have been receiving home health services from an agency that does not have a Network Provider agreement with the Contractor, the Contractor shall pay the Medicaid rate for services provided to an Enrollee by a non-network home health agency until:

(1) the home health agency enrolls as a Network Provider; or

(2) the Contractor provides an assessment and transitions the Enrollee to an in-network home health agency.

(B) The Contractor shall include the Enrollee in developing the plan of care to be provided by the Contractor's Network home health agency before the transition. The Contractor shall make reasonable efforts to address the Enrollee's concerns regarding Covered Services provided by the Contractor's in-network home health agency before the new plan of care is implemented.

11.6.4 Enrollee Transition, Medical Equipment

(A) When the Contractor authorizes medical equipment for an Enrollee and the Enrollee subsequently enrolls in a different MCE or FFS, the Contractor is responsible for the payment of the equipment regardless of when the equipment is received, and until the authorization expires.

(B) When the Department authorizes medical equipment for an Enrollee and the Enrollee subsequently enrolls with the Contractor, the Department is responsible for payment of the equipment regardless of when the equipment is received, and until the authorization expires.

(C) Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment are the responsibility of:

(1) the Contractor if the Enrollee is enrolled with the Contractor at the time the equipment is ordered;

(2) the Department if the Enrollee is Medicaid FFS at the time the equipment is ordered; or

(3) the MCO if the Enrollee is enrolled with an MCO at the time the equipment is ordered.

11.6.5 Contractor's Acceptance of Pre-Enrollment Authorizations

The Contractor shall honor existing Department and other MCE authorizations and reimburse Providers for Covered Services after the Medicaid Member enrolls with the Contractor until the Contractor has evaluated if the service is Medically Necessary and agrees with the authorization, makes a different determination, or makes arrangements to have the services provided by a Network Provider.

11.6.6 Department's Acceptance of Contractor's Authorizations

For Covered Services other than inpatient, home health services, and medical equipment, if the Contractor has authorized a Covered Service and an Enrollee transitions to FFS prior to the delivery of such Covered Service, the Department shall honor the Contractor's authorization until the Department has evaluated the Medical Necessity of the service and agrees with the Contractor's authorization or makes a different determination.

11.6.7 Organ Transplant Service Authorization

The Contractor shall honor prior authorizations for organ transplantations, and any other ongoing services initiated by the Department while the Enrollee was covered under FFS, until the Enrollee is evaluated by the Contractor and a new plan of care is established.

11.6.8 Pharmacy Service Authorizations

The Contractor agrees that during the first 90 days of a Medicaid Member's enrollment with the Contractor that the Department's FFS prior authorization for pharmacy services or a prior authorization which has been issued to a CHIP Enrollee for pharmacy services will be honored for at least one temporary 30-day fill unless the prescription is written for less than 30 days by the prescriber.

11.6.9 Provision of Medical Information to the Department or Other Managed Care Entities

(A) When an Enrollee is transitioned from the Contractor to FFS or from FFS to the Contractor, the Contractor or the Department as applicable shall, upon a written request, submit the requested information up to five years after disenrollment.

(B) When an Enrollee is transitioned from the Contractor to another MCE, the Contractor shall, upon a written request from the Enrollee's new MCE, submit the requested information up to five years after disenrollment.

Article 12: Additional Recordkeeping and Reporting Requirements

12.1 Recordkeeping Requirements

12.1.1 Health Information Systems, Generally

(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's Claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized Claims processing and information retrieval systems in operation by the Department to meet Section 1903(r)(1)(F) of the Social Security Act.

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

(D) The Contractor shall implement and maintain a publicly-accessible standards-based Application Programming Interface (API) that meets the criteria specified in 42 CFR 431.60 and as described in 42 CFR 431.70.

12.1.2 Accuracy of Data

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

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

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

(3) collecting data 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 and upon request to CMS, independent quality review examiners, and other Utah State agencies as allowed by law.

12.1.3 Medical Records

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

12.1.4 Document Retention Requirements for Awards

The Contractor shall comply with the record retention and record access requirements for award recipients found in 45 CFR § 74.53, which requires the Contractor to maintain financial records, supporting documents, statistical records, and all other records pertaining to an award to be retained for a period of three years from the date of submission of the final expenditure report or,

for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual final expenditure 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 three-year period, the records shall be retained until all litigation, Claims, or audit findings involving the records have been resolved and final action taken;

(2) to records for real property and equipment acquired with federal funds, which shall be retained for three years after final disposition;

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

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

12.1.5 Record Retention Requirements, Generally

(A) Unless otherwise specified by this Contract or by federal or State law, the Contractor shall keep all documents and reports required by this Contract for a period of six years. Such documents include, but are not limited to, the attestation forms required by Article 6.3.2 of this attachment, 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 §§ 438.604, 438.606, 438.608, 438.610 for a period of no less than 10 years.

12.2 Additional Reporting Requirements

12.2.1 Independent Financial Audit(s)

The Contractor shall submit its audited financial report to the Department by November 1st of each year. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The audit shall be conducted by an organization that has no internal ties to the Contractor.

12.2.2 Semi-Annual Reports

(A) The following semi-annual reports are due May 1 for the preceding six-month reporting period ending December 31 (July through December) and are due November 1 for the preceding six-month period ending June 30 (January through June): and

(1) reports summarizing information on corrective actions taken on Network Providers who have been identified by the Contractor as exhibiting aberrant behavior.

12.2.3 Grievance and Appeal Reports

On a quarterly basis, the Contractor shall complete the Grievance and Appeal reports using the Department-specified report forms and submit the reports to the Department by the specified due dates.

12.2.4 Reporting of Abortions, Sterilizations, and Hysterectomies

(A) On November 1 of each year, the Contractor shall submit to the Department the following information:

(1) a spreadsheet containing the following information for all abortions, hysterectomies, and sterilizations performed during the prior fiscal year:

(i) client name;

(ii) Medicaid ID number;

(iii) procedure code; and

(iv) date of service;

(2) consent forms for all abortions performed during the prior fiscal year;

(3) consent forms for a sample of 10% of hysterectomies and sterilizations during the prior fiscal year; and

(4) the medical records for all abortions performed during the prior fiscal year.

(B) The Department shall evaluate the documentation requested under Article 12.2.5 of this attachment and may require medical record submission. The Contractor agrees to provide the additional documentation to the Department in the timeframes required by the Department.

12.2.5 Provider Network Reports

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

12.2.6 Case Management Reports

The Contractor shall submit annual case management reports no later than November 1st of each year for the preceding fiscal year. The report shall be in a format designated by the Department.

12.2.7 Hepatitis C Adherence Reports

The Contractor shall submit an annual report demonstrating Enrollee adherence to Hepatitis C medications and treatment plans. The report shall be in a format designated by the Department and shall be due no later than November 1st of each year.

12.2.8 Provider Statistical and Reimbursement Reporting

(A) In accordance with the Utah State Plan Attachment 4.19-B, page 1, incorporated into Utah Administrative Rule R414-1-5, by reference, the Contractor shall provide, upon a Provider's request, a Provider Statistical and Reimbursement (PS&R) report.

(B) The PS&R report shall include statistical data including total covered charges, units, and reimbursement (including outpatient supplemental payments) by fiscal period.

(C) The Contractor shall provide the report within 30 calendar days of the request.

12.2.9 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 timeframes specified by the Department.

12.2.10 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) the results of any Enrollee or Provider satisfaction survey conducted by the Contractor;

(2) medical management committee reports and minutes; and

(3) customer service performance summary data.

12.2.11 Hospital Reporting

(A) In accordance with Utah Code §26-36b-204, the Contractor shall submit a report to the Department for the prior fiscal year, in a format designated by the Department.

(B) In accordance with R414-511-3, the Contractor shall submit a report to the Department for the prior fiscal year, in a format designated by the Department.

12.2.12 Parties in Interest

(A) The Contractor shall report to the Department, and upon request, to the Secretary of HHS, the HHS Inspector General, and the Comptroller General, a description of transactions between the Contractor and a party in interest as defined by Section 1318(b) of the Public Health Services Act, including the following transactions:

(1) any sale or exchange, or leasing of any property between the Contractor and such a party;

(2) any furnishing for consideration of goods, services, (including management services) or facilities between the Contractor and such party, but not including salaries paid to employees for services provided in the normal course of their employment; and

(3) any lending of money or other extension of credit between the Contractor and such a party.

12.2.13 Member Engagement Quarterly Reporting

(A) The Contractor shall submit, by the 15th of the month following each quarter, the following reports in a Department specified format based on its Member Engagement Panel Activities:

(1) a report detailing the Contractor's Member Engagement Panel activities.

(2) a report describing the Contractor's efforts regarding initial Enrollee contact.

(3) a report documenting the barriers identified, tools used to address barriers, and success of the tools used to address barriers.

12.2.14 Health Plan Accreditation Reports

(A) The Contractor shall maintain or work towards achieving NCQA health plan accreditation during the contract year.

(B) The Contractor shall submit an annual report by the 15th of the month after the end of the fiscal year, detailing; activities engaged in during the last fiscal year to remain accredited or become accredited, as well as detailing planned activities for the upcoming fiscal year to remain accredited or become accredited.

(C) If not already accredited, the Contractor shall submit a quarterly report by the 15th of the month following each quarter, demonstrating progress toward achieving health plan accreditation.

(D) The Department shall recoup all quality payments made for health plan accreditation if the Contractor is not accredited by July 1, 2027.

12.3 Encounter Data

12.3.1 Encounter Data, Generally

(A) In accordance with 42 CFR § 438.242(c), the Contractor shall collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers Covered Services to Enrollees.

(B) The Contractor shall transmit Encounter Data to the Department using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR 162.1101 and 162.1102.

(C) The Contractor shall transmit all Encounter Data to the Department, including allowed amount and paid amount, which the Department is required to report to CMS under 42 CFR § 438.818.

(D) The Contractor shall transmit all Encounter Data to the Department in accordance with the X12 Standards for Electronic Data Interchange, Health Care Claim: 837 Institutional and Professional Guides as well as the Department's 837 Companion Guides for Institutional and Professional Encounters, as amended.

(E) The Contractor shall transmit Encounter Data within 30 calendar days of the service or Claim adjudication date. The Encounter Data shall represent all Encounter Claim types (professional and institutional) received and adjudicated by the Contractor.

(F) If the Contractor is submitting an Encounter which was adjudicated by a Subcontractor, the Contractor shall submit the Encounter Data within 30 calendar days of receipt from the Subcontractor if the Subcontractor does not submit the Encounter Data directly to the Department.

(G) If the Contractor fails to transmit at least 95 percent of its Encounter Data within the timely submission standard in Article 12.3.1(E) of this attachment, the Department may require corrective action.

(H) The Contractor shall transmit Encounter Data for all services rendered to Enrollees under this Contract, including:

(1) services for which the Contractor determined no liability exists;

(2) services for which the Contractor did not make any payment, including services provided under a subcontract, Capitation or special arrangement with another facility or program; and

(3) services for Enrollees who also have Medicare coverage, if a Claim was submitted to the Contractor.

(I) The Contractor shall submit corrections to all rejected Encounter Data within 45 calendar days of the date the Department sends notice that the Encounter Data has been rejected.

(J) If the Contractor discovers that Encounter Data for services and/or costs of Excluded Providers have been included in the submitted Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter Data.

(K) The Department shall edit Encounter Data in accordance with HIPAA standards and Department instructions. The Department shall reject Encounter Data that are incomplete or that include incorrect codes.

(L) The Department shall notify the Contractor of the status of rejected Encounter Data by sending the Contractor a 999 Implementation Acknowledgement for Health Care Insurance or a TA1 Interchange acknowledgment regarding file acceptance. The Department shall send the Contractor a 277 Health Care Claim Status Response Transaction advising the Contractor of the status of the processed Claims. The Contractor shall be responsible for reviewing the 999, TA1, and 277 transactions and taking appropriate action when necessary.

12.3.2 Encounter Data Validation

(A) The Contractor shall conduct quarterly Encounter Data validations. To facilitate the validation, the Department shall send the Contractor an Encounter Data validation questionnaire, and an Encounter Data submission detail file comprised of all accepted Encounter Data for the specified quarter that may be used for rate setting.

(B) The Contractor shall respond to the Department's Encounter Data validation questionnaire within 14 calendar days from the date the Department sends the questionnaire and the Encounter Data submission detail file.

(C) If the Contractor fails to comply with the Encounter Data validation process, the Department may require corrective action.

12.3.3 Encounter Data for Rate Setting

The Department shall use for rate setting only the Encounter Data received by the Department's deadline.

12.3.4 Post-Adjudication History Pharmacy File

(A) The Contractor shall electronically submit a post-adjudication history file to the Department. The post-adjudication history file shall be in a format requested by the Department and shall be based on the National Council for Prescription Drug Programs (NCPDP) format. The Contractor shall submit its post-adjudication history file at the end of every batch cycle whether the batch is weekly, every two weeks, or every two months.

(B) The Contractor must ensure that its post-adjudication history file is accurate.

(C) The Contractor shall correct any errors found in the post-adjudication history file within 45 calendar days of the discovery of the error by the Contractor or Department. If the Contractor fails to correct the errors found in the post-adjudication history file, the Department may impose sanctions as described in Article 14 of this attachment.

12.3.5 Non-Encounter Data

The Contractor shall submit a non-Encounter Data report to the Department on November 1st each year. The report shall be in a Department-specified format. The Contractor shall follow the Department's instructions in filling out the report and shall not change the format of the report.

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

(B) The Contractor shall reverse the Encounter Data for the incorrectly paid Claims within 60 calendar days of the earlier of the Date of Discovery of an incorrectly paid Claim or the date of the notice of a disallowance of an incorrectly paid Claim. The Contractor shall correct any Encounter Data for any incorrectly paid Claim regardless of whether the Contractor is successful in collecting the payment from the Provider.

(C) Failure to properly reverse or adjust Encounter Data will result in sanctions allowed by Article 14 of this attachment.

(D) The Contractor shall make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

(1) the Provider has submitted a Claim for the date of service within 12 months of the date of service;

(2) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had TPL that should have paid on the Claim;

(3) the Provider can show, through Explanation of Benefits (EOB) statements or other sufficient evidence that the TPL was either not in effect or will not cover the billed service; and

(4) absent the coordination of benefits issues or the timely filing issues, the Claim is otherwise payable.

12.5 Medical Loss Ratio

12.5.1 Medical Loss Ratio, Generally

(A) The Contractor shall calculate and submit to the Department an annual MLR consistent with the MLR standards found Article 12.5 of this attachment and the Department's MLR instructions document. The Department shall make a good faith effort to give the Contractor any supplemental instructions 90 calendar days in advance of the MLR calculation being due.

(B) The Contractor shall create separate MLR data for the Legacy Medicaid Population eligibility groups and the Adult Expansion Population eligibility groups covered under the Contract.

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 a pro rata basis.

(D) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(E) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(F) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of Claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

(G) The Contractor shall ensure that prescription drug rebates are Excluded from the amount of actual Claims costs used to calculate an MLR. When calculating an MLR, prescription drug rebates means any price concession or discount received by the managed care plan or its Pharmacy Benefit Manager, regardless of who pays the rebate or discount.

(H) The Contractor shall ensure that any amount retained by a pharmacy benefit manager under spread pricing is excluded from the amount of Claims costs used for calculating the MLR.

(I) The MLR calculation will only include shared savings payments, profit sharing payments, etc. where:

(1) the payments require Network Providers to improve their performance on clinical or quality improvement standards or metrics;

(2) the performance period aligns with the MLR reporting period;

(3) the Network Provider Agreements outlining the payments are signed before the start of the performance period; and

(4) the payments are not directly or indirectly based on the Health Plan's MLR or profitability, as determined by the Department.

12.5.3 Medical Loss Ratio, Credibility Adjustment

(A) The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

(B) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department.

(C) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(D) If the Contractor’s experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

12.5.4 Medical Loss Ratio, Reporting

(A) The Contractor shall submit a MLR report to the Department that includes, for each MLR reporting year:

(1) total incurred Claims;

(2) expenditures on quality improving activities;

(3) expenditures related to Fraud prevention activities as defined in 42 CFR § 438.8(e)(4);

(4) non-Claim costs;

(5) premium revenue;

(6) taxes;

(7) licensing fees;

(8) regulatory fees;

(9) methodology(ies) for allocation of expenditures;

(10) any credibility adjustment applied;

(11) the calculated MLR;

(12) any remittance owed to the Department (if applicable);

(13) a comparison of the information reported with the audited financial report;

(14) a description of the aggregation method used to calculate total incurred Claims; and

(15) the number of member months.

(B) The Contractor shall submit the MLR report in a Department-specified format no later than December 31st of each year, unless an alternative date is agreed to by the Parties.

(C) The Contractor shall require any third party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 calendar days of the end of the MLR reporting year or within 30 calendar days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(D) In any instance where the Department makes a retroactive change to the Capitation Payments for an MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and submit a new MLR report meeting the applicable requirements.

(E) The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

12.6 Data Submission and Certification

12.6.1 Data Submission

(A) The Contractor shall submit the following data to the Department that are subject to the certification requirements found in Article 12.6.2 of this attachment:

(1) Encounter Data in the form and manner described in 42 CFR § 438.818 and this Contract;

(2) Data on the basis of which the Department certifies the actuarial soundness of Capitation Rates to the Contractor under 42 CFR § 438.4, including base data described in 42 CFR § 438.5(c) that is generated by the Contractor;

(3) Data on the basis of which the Department determines the compliance of the Contractor with the MLR requirement described in this Contract and 42 CFR § 438.8;

(4) Data on the basis of which the Department determines that the Contractor has made adequate provision against the risk of insolvency as required under this Contract and 42 CFR § 438.116;

(5) Documentation described in 42 CFR § 438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR § 438.206;

(6) Information on ownership and control described in this Contract, 42 CFR § 455.104 and 42 CFR § 438.230; and

(7) The 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 § 438 as required by the Department or the Secretary of HHS.

12.6.2 Data Certification

(A) By submitting data, documentation, or information described in Article 12.6.1 of this attachment to the Department, the Contractor certifies and attests that, based on best information, knowledge, and belief, the data, documentation, and information are accurate, complete, and truthful.

(B) The data, documentation, or information required by Article 12.6.1 of this attachment shall be certified by:

(1) the Contractor's 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.

12.6.3 Publicly Reporting Service Authorization Data

In accordance with 42 CFR § 438.210(f), beginning with Service Authorization data from calendar year 2025, the Contractor shall report Service Authorization data, excluding data on any and all drugs covered by the Contractor, by posting the data on its publicly-accessible website by March 31 of the following calendar year. The following data shall be reported:

(1) A list of all Covered Services that require Service Authorization;

(2) Standard Service Authorization Requests:

(i) The percentage of standard Service Authorization Requests that were approved, aggregated for all Covered Services;

(ii) The percentage of standard Service Authorization Requests that were denied, aggregated for Covered Services;

(iii) The percentage of standard Service Authorization Requests that were approved after an Appeal decision, aggregated for Covered Services;

(iv) The percentage of standard Service Authorization Requests for which the timeframe for review was extended, and the request was approved, aggregated for all Covered Services; and

(v) The average and median time that elapsed between the submission of a standard Service Authorization Request and a determination by the Contractor, aggregated for all Covered Services; and

(3) Expedited Service Authorization Requests:

(i) The percentage of expedited Service Authorization Requests that were approved, aggregated for all Covered services;

(ii) The percentage of expedited Service Authorization Requests that were denied, aggregated for all Covered Services;

(iii) The percentage of expedited Service Authorization Requests that were approved after an Appeal decision, aggregated for all Covered Services;

(iv) The percentage of expedited Service Authorization Requests for which the timeframe for review was extended, and the request was approved, aggregated for Covered Services; and

(v) The average and median time that elapsed between the submission of an expedited Service Authorization Request and a determination by the Contractor, aggregated for all Covered Services.

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;

(2) services performed or determinations of amounts payable under the Contract; or

(3) any other audit allowed by State or federal law.

(B) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah State agencies as allowed by law any of the Contractor's records that may reasonably be requested to conduct the audit.

(C) The Contractor shall, in accordance with 45 CFR 74.48 (and except for contracts less than the simplified acquisition threshold), allow the HHS awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

13.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah State agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other Enrollee data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the Utah OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid related activities or work is conducted. This right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

13.1.3 Information to Determine Allowable Costs

(A) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah State agencies as allowed by law, all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the Medicaid program for "related party/home office" transactions, as defined by CMS Manual 15-1.

(B) The records described in Article 13.1.3(A) of this attachment shall be made available in Salt Lake City, Utah or the Contractor shall pay the increased cost of auditing at an out-of-state location. The increased costs shall include round-trip travel and two days of lodging and

per diem. Additional travel costs of the out-of-state audit shall be shared equally by the Contractor and the Department.

13.1.4 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other 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 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 of Medicaid funds received by the Contractor as allowed by Utah Code Ann. §63J-4a-202(2).

(1) Records requested by the Utah OIG must be provided within 30 calendar days in accordance with Utah Administrative Code R367-1-7.

(2) The Utah OIG shall determine the Medical Necessity and appropriateness of inpatient admissions during utilization review by use of an evidence-based review criteria process standard in accordance with Utah Administrative Code R367-1-7(3)(b).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. §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 shall comply with the terms of a Department-issued corrective action plan and shall complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan. If the Contractor fails to satisfactorily complete the Department's corrective action plan, the Department may assess liquidated damages in accordance with Article 14.3 of this attachment.

(C) If the Contractor disagrees with the Department's corrective action plan, the Contractor may file a request for an administrative hearing within 30 calendar days of receipt of the Department's corrective action plan.

14.1.3 Contractor-Generated Corrective Action Plans

(A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.

(B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.

(C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 calendar days of receipt. In the event the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised. The corrective action plan

submitted by the Contractor shall be deemed approved by the Department if the Department fails to respond to the Contractor within 20 calendar days of receipt of the Contractor's corrective action plan.

(D) The Contractor shall comply with the terms of a Department-approved corrective action plan and shall complete all required actions within the required timeframes. If the Contractor fails to satisfactorily complete the Department's corrective action plan, the Department may assess liquidated damages in accordance with Article 14.3 of this attachment.

14.1.4 Notice of Non-Compliance

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and timeframe in which the Contractor's non-compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 calendar days to cure its non-compliance. However, the Department may shorten the 30-calendar daytime period in the event that a delay would endanger an Enrollee's health, or the timeframe must be shortened in order for the Department and the Contractor to meet federal guidelines.

(B) If the Contractor fails to cure the non-compliance as ordered by the Department and within the timeframes designated by the Department, the Department may, at its discretion, impose any or all of the following sanctions:

(1) suspension of the Contractor's Capitation Payment;

(2) assessment of Liquidated Damages;

(3) assessment of civil monetary penalties; and/or

(4) imposition of any other sanction allowed by federal and State law.

(C) The Department agrees that it shall not, for an individual event of the Contractor's non-compliance, impose both liquidated damages and the suspension of the Contractor's Capitation Payment. The Department may choose to either suspend the Capitation Payment or impose liquidated damages.

(D) The Department's imposition of any of the sanctions described in Article 14.1.4(B) of this attachment is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in Article 14.1.4(B) of this attachment 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) In addition to other remedies allowed by law and unless specified otherwise, the Department may suspend Capitation Payments to the Contractor if the Contractor:

(1) fails to comply with any provision of this Contract;

(2) fails to provide the requested information within 30 calendar days from the date of a written request for information, or by a mutually agreed upon date by the Parties;

(3) has an outstanding balance owed to the Department for any reason; or

(4) fails to submit or comply with a corrective action plan within the timeframes required by the Department.

(B) The Department shall provide written notice before suspending payments ten calendar days prior to the suspension of Capitation Payments.

(C) When the Department rescinds suspension of Capitation Payments, it will, without notice, resume payments according to the regular payment cycle.

14.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 calendar days.

(B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments, the Contractor may request an administrative hearing within 30 calendar days of receipt of the Department's notice of intent to suspend the Capitation Payments. The Department may continue to withhold Capitation Payments through the duration of the administrative hearing, unless ordered by the hearing officer to release the Capitation Payments.

14.3 Liquidated Damages

14.3.1 Liquidated Damages, Generally

(A) If the Contractor fails to perform or does not perform in a timely manner provisions under this Contract, damages to the Department may result. The Parties agree that the resulting damages may be very difficult to accurately estimate.

(B) If the Contractor completes a corrective action plan and then subsequently fails to perform based on the corrective action plan, the Department may assess liquidated damages rather than requiring a follow-up corrective action plan for the same issue.

(C) Should the Department choose to impose liquidated damages, the Parties agree that the following damages provisions represent a reasonable estimation of the damages that would be suffered by the Department due to the Contractor's failure to perform. Such damages to the Department would include additional costs of inspection and oversight incurred by the Department due to the Contractor's non-performance or late performance of any provision of this Contract.

(D) At its discretion, the Department may withhold liquidated damages from the Department's Capitation Payment to the Contractor.

(E) If the Department chooses to impose liquidated damages, the Department shall provide the Contractor with written notice of its intent to impose liquidated damages.

(F) If the Contractor disagrees with the reason for the imposition of liquidated damages, the Contractor may request a State Fair Hearing within 30 calendar days of receipt of the Department's notice of intent to impose liquidated damages. The Department may impose liquidated damages through the duration of the State Fair Hearing unless the State Fair Hearing officer orders that the imposition of liquidated damages should be discontinued throughout the State Fair Hearing process.

(G) Each category of liquidated damages found in Article 14.3.2 and Article 14.3.3 of this attachment is exclusive, meaning that for any individual event of non-compliance by the Contractor the Department may only assert one category of liquidated damages. For example, if the Department imposes liquidated damages of $500 per calendar day for failure to comply with a corrective action plan, it may not also impose for the same event liquidated damages of $300 per calendar day for failure to submit documents to the Department. Furthermore, each imposition of liquidated damages must be based on actual failure of the Contractor to comply with the terms of this Contract, and no event of noncompliance may be extrapolated to other unsubstantiated claims of noncompliance.

(H) In no event will the Contractor's cumulative liability under Article 14.3 of this attachment be more than $1,000,000 per calendar year.

(I) The Department's ability to assess liquidated damages under Article 14.3 of this attachment is limited to the Contractor. In no event will liquidated damages under Article 14.3 of this attachment be assessed against the Contractor's parent company or any other affiliate of the Contractor.

(J) In no event may liquidated damages be retroactively assessed against the Contractor for failures to comply with the terms of this Contract that occurred more than one year prior to the discovery of the failures except in cases involving Fraud, Waste, and Abuse.

14.3.2 Liquidated Damages, Per Day Amounts

(A) The Department may assess the following damages against the Contractor for each date beyond the deadline that the Contractor was required to take the following actions:

(1) $300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;

(2) $400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;

(3) $1,000 per calendar day the Contractor fails to submit accurate and complete Encounter Data (as required by Article 12.3 of this attachment) or Post Adjudication Pharmacy file (as required by Article 11.3.3(B) of this attachment);

(4) $2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the timeframes established under Attachment D;

(5) $500 per calendar day the Contractor fails to submit or comply with corrective action plan;

(6) $500 per calendar day that the Contractor fails to provide audit access as required by Article 13.1 of this attachment;

(7) $1,000 per calendar day for each day that the Contractor does not comply with the Fraud and Abuse provision found in Article 6 of this attachment and such failure requires Department intervention;

(8) $5,000 per calendar day that the Contractor fails to maintain a complaint and Appeal system as required by this Contract and such failure requires Department intervention; and

(9) $500 per calendar day for other violations of 42 CFR § 438 which requires Department intervention or supervision.

14.3.3 Additional Liquidated Damages

(A) The Department may assess and impose the following liquidated damages against the Contractor:

(1) $1,000 per each occurrence that the Contractor fails to properly credential a Network Provider as required by Article 5.3 of this attachment (including a failure to search the LEIE database, or has Provider agreements that do not meet the requirements of Article 5.3 of this attachment) and such failure to credential requires Department intervention or supervision; and

(2) $1,000 per each occurrence where the Contractor fails to provide an Enrollee access to Covered Services as required by this Contract and such failure requires Department intervention or supervision.

14.4 Sanctions Allowed by Federal Law

14.4.1 Reasons for Imposition of Intermediate Sanctions

(A) In accordance with 42 CFR § 438.700, the Department may impose intermediate sanctions when the Department determines that the Contractor:

(1) fails substantially to provide Medically Necessary Covered Services that the Contractor is required to provide, under law or under this Contract with the Department, to an Enrollee covered under this Contract;

(2) imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(3) acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicates probable need for substantial future medical services;

(4) misrepresents or falsifies information that it furnishes to CMS or the Department;

(5) misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or Provider;

(6) fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR § 422.208 and 42 CFR § 422.210;

(7) has distributed directly or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the Department or that contain false or materially misleading information;

(8) prohibits or restricts a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient for any of the reasons listed in 42 CFR § 438.102(a)(1); or

(9) has violated any of the other applicable requirements of Section 1903(m) or Section 1932 of the Social Security Act and its implementing regulations.

(B) In the event that the Contractor fails to safeguard Enrollee Protected Health Information the Contractor shall be subject to sanctions imposed by CMS pursuant to HIPAA and HITECH.

14.4.2 Types of Intermediate Sanctions

(A) The Department may impose any or all of the following intermediate sanctions:

(1) civil monetary penalties in the amounts specified in 42 CFR § 438.704; and

(2) appointment of temporary management of the Contractor as provided in 42 CFR § 438.706 and this Contract.

(B) The Department may impose additional sanctions provided for under State statutes or rules to address noncompliance.

14.4.3 Notice of Sanction

(A) In accordance with 42 CFR § 438.710, the Department shall provide the Contractor with timely written notice before imposing any of the intermediate sanctions specified in Article 14.4.2 of this attachment. The notice shall explain the basis and the nature of the sanction.

(B) The Contractor has 30 calendar days to provide a written response to the Department.

(C) If the Contractor disagrees with the imposition of any of the sanctions specified in Article 14.4.2 of this attachment, the Contractor may request a State Fair Hearing. The Department may continue to impose the Sanction through the duration of the State Fair Hearing unless the hearing officer orders otherwise.

14.4.4 Discretionary Imposition of Temporary Management

(A) Pursuant to 42 CFR § 438.706, the Department may impose temporary management of the administration of the Contractor's Medicaid operations only if it finds (through onsite surveys, Enrollee or other complaints, financial status, or any other source) that:

(1) there is continued egregious behavior by the Contractor in accordance with 42 CFR § 438.700;

(2) there is substantial risk to the Enrollee's health; or

(3) the sanction is necessary to ensure the health of the Contractor's Enrollees while improvements are made to remedy violations under 42 CFR § 438.700 or until there is an orderly termination or reorganization of the Contractor.

14.4.5 Required Imposition of Temporary Management

(A) In accordance with 42 CFR § 438.706, the Department shall impose temporary management of the administration of the Contractor's Medicaid operations (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act.

(B) The Department shall grant Enrollees the right to terminate enrollment without cause and shall notify Enrollees of their right to terminate Enrollment.

14.4.6 Hearing on Temporary Management

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

14.4.7 Duration of Temporary Management

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

14.4.8 Sanctions Imposed by CMS: Denial of Payment

The Department may recommend that CMS deny payments for new Enrollees in accordance with 42 CFR § 438.730.

Article 15: Termination of the Contract

15.1 Automatic and without Cause Termination

15.1.1 Automatic Termination

This Contract shall automatically terminate on June 30, 2027.

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 calendar days prior to the termination date. The termination notice must be on the first business day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 calendar days written notice.

15.1.3 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 date of the calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or 30 calendar days following termination, whichever occurs first.

(B) Upon any termination of this Contract, the Contractor shall promptly supply to the Department all 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 for Cause

15.2.1 Termination of Contract for Cause, Generally

(A) In accordance with 42 CFR § 438.708, the Department may terminate this Contract and enroll the Contractor's Enrollees in other MCEs 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;

(2) meet the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act; or

(3) The Department shall exclude from participation any MCO that has prohibited relationships as defined in 42 CFR § 1002.203.

15.2.2 Pre-Termination Hearing

(A) In accordance with 42 CFR § 438.710, before terminating the Contract pursuant to Article 15.2.1 of this attachment, the Department must provide the Contractor with a pre-termination hearing. The Department shall:

(1) give the Contractor written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;

(2) after the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of the termination; and

(3) for an affirming decision, give Enrollees notice of termination and information consistent with 42 CFR § 438.10, on their options for receiving Medicaid services following the effective date of the termination.

(B) In accordance with 42 CFR § 438.722, after the Department notifies the Contractor that it intends to terminate the Contract, the Department may give Enrollees written notice of the Department's intent to terminate the Contract and may allow Enrollees to disenroll immediately, without cause.

15.2.3 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

15.3 Close Out Provisions

15.3.1 Close out Provisions and Transition Plan

(A) Notwithstanding any provision found in Attachment A, in the event of termination of this Contract, the Contractor shall complete any and all duties required by this Contract.

(B) In the event of termination of this Contract, the Contractor shall work with the Department to create a transition plan that addresses its administrative duties and the transition of care for Enrollees. The Contractor's transition plan shall include but not be limited to:

(1) providing written notification of the Contractor's termination to all Enrollees at least 60 calendar days prior to the termination date of the Contract unless otherwise directed by the Department;

(2) processing and paying any Claims generated during the lifetime of this Contract including completing Appeals by Providers and/or Enrollees and any monetary reconciliations;

(3) providing the Department with complete and accurate Encounter Data for all Encounters generated during the lifetime of this Contract;

(4) providing the Department with reports as required by this Contract and any other ad-hoc reports required by the Department;

(5) complying with any audit requests; and

(6) orderly and reasonable transfer of care for Enrollees.

(C) With the exception of retroactive Capitation Payments, the Department shall cease enrollment of Medicaid Individuals and Capitation Payments for dates following the termination of this Contract.

(D) The Contractor shall not accept any payments from the Department after the termination of this Contract, unless payment is for the time period covered under this Contract. If the Contractor determines the Department has made a payment in error, the Contractor shall notify the Department in accordance with Article 11.1.5(A) of this attachment.

(E) The Department may withhold any payments due under this Contract until the Department receives from the Contractor any written and properly executed documents as required by written instructions from the Department.

(F) Failure of the Contractor to comply with the provisions found in Article 15.3 of this attachment 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 precede the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof. Notwithstanding Attachment A, General Provisions, Article III, item 52, if there is a conflict between this Attachment B, Scope of Work, and the Attachment A, General Provisions, then this Attachment B shall control.

16.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

16.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of federal and State law.

16.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

16.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

16.1.6 Continuation of Services during Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly Capitation Payments to the Contractor.

16.1.7 Surveys

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

16.1.8 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's policies and procedures in provider manuals and MIBs, and shall ensure that the Contractor and its Network Providers comply with the policies and procedures in effect at the time Covered Services are rendered.

(B) The Contractor shall comply with all appropriate and applicable federal and State rules and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

16.1.9 Solvency Standards

(A) Unless exempt, the Contractor shall comply with 42 CFR § 438.116, and provide assurances satisfactory to the Department showing that provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the Contractor's debts if the Contractor becomes insolvent.

(B) Unless exempt under 42 CFR 438.116(b)(2), the Contractor shall meet the solvency standards required by 42 CFR 438.116(b)(1).

16.1.10 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor, nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

16.1.11 CMS Approval of Contract

(A) The Contractor understands and agrees that this Contract is subject to approval by CMS. The Contractor agrees to execute any amendment necessary to make this Contract compliant with any CMS requirements. The Contractor shall be responsible for repayment of any disallowances of FFP in the event the Contractor refuses to execute a contract amendment to bring the Contract into compliance with any CMS requirements.

(B) The Contractor shall not be responsible for any disallowance of FFP imposed by CMS prior to CMS formal approval of the Contract and related Capitation Rates.

16.2 Access to the Controlled Substance Database

16.2.1 Application for Access

(A) In accordance with Utah Code Ann. §58-37f-301(2)(g), the Contractor may make a written application to the Department for authorization for its employees to have access to the Controlled Substance Database.

(B) When designating an employee as needing access to the Controlled Substance Database the Contractor shall certify that the person is employed by the Contractor.

16.2.2 Criminal Background Report

(A) The Contractor shall conduct a criminal background report for each employee which the Contractor is applying for access to the Controlled Substance Database.

(B) The criminal background report shall be issued by the Utah Bureau of Criminal Identification and shall be provided to the Department as part of the Contractor's application for employee access to the Controlled Substance Database.

(C) The Department shall approve access to any Contractor's employee whose criminal background report shows that the employee has not been arrested, charged, or Convicted of any misdemeanor or felony within the last 10 years. If the criminal background report shows that an applicant has been Convicted of any misdemeanor or felony within the past 10 years, then the Department and DOPL must each approve authorization of the Contractor's employee based upon the nature of the criminal offense that resulted in the conviction and the criteria set forth in Utah Administrative Code R156-1-302 and R156-1-102(2) and (16).

(D) The Contractor shall conduct the criminal background report at its own cost.

16.2.3 Employee Compliance with State Law

(A) Each employee who is granted access to the Controlled Substance Database shall comply with the Utah Government Records Access and Management Act (GRAMA), Utah Code Ann §63G-2-101, et seq. and the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, et seq. Each employee must comply with the following:

(1) All information in the database falls within the definition of record in the GRAMA. All records in the database are records of DOPL. Pursuant to the provisions of GRAMA, records in the database are not public and access to those records is governed by the provisions of the Controlled Substance Database statute. (See Utah Code Ann. § 63G-2-201(3)(b); § 63G-2-201(6)(a); and 58-37f-101 through 801.).

(B) The Contractor shall be responsible for ensuring that its employees who have access to the Controlled Substance Database understand their compliance responsibilities as described in Article 16.2.3(A) of this attachment and shall provide any necessary training to their employees.

16.2.4 Limitation of Database Searches

The Contractor shall ensure that each of its employees who are authorized by the Department to access the Controlled Substance Database shall limit their searches of the Controlled Substance database to current Enrollees who are suspected of improperly obtaining or providing a controlled substance.

16.2.5 Search Submitted Directly to the Department of Commerce

(A) The Contractor shall ensure that its employees who have been given access to the Controlled Substance Database shall submit any request for database information directly to the Department of Commerce. The requests shall be in writing via letter, fax, or email.

(B) The Department of Commerce shall review the request for database information and may request additional information. If the request for database information is satisfactory, the

Department of Commerce will conduct the database search and download the database information.

16.2.6 Employee Acknowledgement

Any employee who has been authorized by the Department to access the Controlled Substance Database shall be required to sign an acknowledgement regarding their access as required by the Department and the Utah Department of Commerce prior to gaining access to the Database. The acknowledgement shall include the language found in Article 16.2.7 of this attachment which may be subject to change.

16.2.7 Language of Employee Acknowledgement

(A) As an MCO employee authorized to request information from the Utah Controlled Substance Database, I understand and acknowledge that I will comply with the following statutes:

(1) Utah Code Ann. § 58-37f-301(2)(f) provides that the database manager shall provide database information:

(i) in accordance with the written agreement entered into with the Department, and the Department of Health, authorized employees of a MCO, as defined in 42 C.F.R. 438.116(b)(1), the MCO contracts with the Department of Health under the provisions of Section 26-18-405, and the contract includes provisions that:

(a) require an MCO employee who will have access to information from the database to submit to a criminal background check;

(b) limit the authorized employee of the MCO to requesting either the Division or the Department of Health to conduct a search of the database regarding a specific Enrollee and to report the results of the search to the authorized employee; and

(c) the information is requested by an authorized employee of the MCO in relation to a person who is enrolled in the Medicaid program with the MCO, and the MCO suspects the person may be improperly obtaining or providing a controlled substance.

(2) Utah Code Ann. § 58-37f-601(1), which provides that:

(i) any person who knowingly and intentionally releases any information in the database or knowingly and intentionally releases any information obtained from other State or federal prescription monitoring programs by means of the database in violation of the limitations under Utah Code Ann. § 58-37f-601 Part 3, Access and Utilization, is guilty of a third-degree felony.

(3) Utah Code Ann. § 58-37f-601(2), which provides that:

(i) any person who obtains or attempts to obtain information from the database or from any other State or federal prescription monitoring programs by means of the database by misrepresentation or Fraud is guilty of a third-degree felony.

(4) Utah Code Ann. § 58-37f-601(3), which provides, in part, that:

(i) a person may not knowingly and intentionally use, release, publish, or otherwise make available to any other person or entity any information obtained from the database or from any other State or federal prescription monitoring programs by means of the database for any purpose other than those specified in Utah Code Ann. § 58-37f-601 Part 3, Access and Utilization; and

(ii) each separate violation of this Subsection (3) is a third-degree felony and is also subject to a civil penalty not to exceed $5,000;

(B) As an authorized MCO employee, I shall strictly limit my investigation and my request for database information to subjects who:

(1) are enrolled in the Medicaid program with my MCO; or

(2) are suspected of improperly obtaining or providing a controlled substance, as specifically set forth in Utah Code Ann. § 58-37f-301(2)(g).

(C) As an authorized MCO employee, I shall not release any database information to any unauthorized person, including persons within my MCO who are not authorized to view the information, unauthorized employees of the Department, or any unauthorized law enforcement or prosecutorial agency. I acknowledge that database information shall not be used as evidence in any administrative, civil, or criminal litigation.

16.2.8 Employee Termination

The Contractor shall immediately notify the Department and the Utah Department of Commerce when any employee who has been granted access to the Controlled Substance database has terminated employment with the Contractor or who no longer requires access to the Controlled Substance Database as part of their job duties.

16.2.9 Termination of Access

(A) The Department or the Utah Department of Commerce may unilaterally terminate access of any authorized employee to the Controlled Substance Database at any time if the Department or DOPL determines that the authorized employee has violated any of the provisions set forth in the access agreement described in Article 16.2 of this attachment, any statute, or any administrative rule governing the Controlled Substance Database.

(B) Any decision to terminate access to the Controlled Substance Database may be reviewed by the Executive Director of the Utah Department of Commerce.

16.2.10 Hold Harmless

The Contractor shall hold the Department harmless from and against any claims, damages, causes of action, losses, and expenses that arise out of any violation of the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, et seq. or its implementing regulations committed by the Contractor, its employees, or Subcontractors.

16.3 Data Security Provisions

16.3.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other State or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

16.3.2 Network Security

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

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

(1) standards which the State applies to its own network as found at http://dts.utah.gov/policies;

(2) current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) any industry-accepted standards that are comparable to those described in Article 16.3.2(B)(1) or Article 16.3.2(B)(2) of this attachment.

16.3.3 Data Security

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

(1) standards that are at least as good as or better than that maintained by the State of Utah found at http://dts.utah.gov/policies;

(2) current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) any industry accepted standards that are comparable to those described in Article 16.3.3(A)(1) or Article 16.3.3(A)(2) of this attachment.

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

16.3.4 Data Transmission

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

16.3.5 Data Storage

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

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

16.3.6 Data Re-Use

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

16.3.7 Notification of Confidential Data Breach

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

16.3.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the duty of confidentiality found in Article 16.3.1 of this attachment and the Confidential Data requirements found between Article 16.3.2 and Article 16.3.7 of this attachment to all Subcontractors used by the Contractor.

16.3.9 Access to State Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to any database maintained by the Department or by the State 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 an annual 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 have access to a Department or State-maintained database.

16.4 Health Information Technology Standards

The Contractor shall comply with the applicable requirements for health information technology standards as described in 45 CFR 170 subpart B and the Interoperability Standards Advisory (ISA) by federally required deadlines.

16.5 Telephone Consumer Protection Act (TCPA)

(A) The Contractor shall comply with the applicable requirements of the Telephone Consumer Protection Act (TCPA) as described in 47 USC § 227 and any FCC declaratory ruling(s) related to the TCPA.

(B) The Contractor is permitted to utilize text messaging to contact Enrollees. As a covered entity the Contractor shall assume all liabilities, risks, and responsibilities to maintain data security required by but not limited to HIPAA, HITECH, and TCPA requirements.

Attachment C - Covered Services

Article 1: Covered Services, Limitations, and Carved Out Services

1.1 Covered Services

1.1.1 Covered and Carved Out Services, Generally

(A) The Contractor shall administer Covered Services in accordance with the Department's Medicaid provider manuals. These Medicaid provider manuals provide detailed information regarding Covered Services and are available to the Contractor on the Department's website.

(B) The Contractor shall cover all services and codes that Medicaid covers under the State Plan except when the service is:

(1) specifically listed in this Contract as being "carved out" of this Contract;

(2) otherwise limited by this Contract; or

(3) limited by service limitations found in the State Plan.

(C) The Parties agree that the State Plan, the Department's 1915(b) waivers, Utah's Medicaid Reform 1115 Demonstration, the Department's provider manuals, MIBs, and Coverage and Reimbursement Look-up Tool, are the official publications of the specific services and codes that Medicaid covers. In the event of a conflict between the State Plan, the Department's 1915(b) waivers, Utah's Medicaid Reform 1115 Demonstration, the Department's Provider manuals, MIBs, and Coverage and Reimbursement Look-up Tool, the Department retains the right to determine whether the services are Covered Services under this Contract.

(D) The Department shall have the right to interpret the publications specified in Article 1.1.1(C) of this attachment.

(E) 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.

(F) Covered Services can only be limited through utilization criteria based on Medical Necessity.

1.2 Carved Out Services

The Contractor is not responsible to cover the following:

(1) dental services including orthodontics and anesthesia for dental services except as provided in Article 1.3.29 of this attachment and Article 1.3.33 of this attachment;

(2) targeted case management: The following codes are carved out except as provided in Article 1.3.27 of this attachment: T1017, T1023;

(3) emergency transportation services;

(4) care in a Nursing facility, Intermediate Care Facility (ICF or ICF-ID), or a Long Term Acute Care Hospital when the prognosis indicates that a stay longer than 30 days will be required (see Article 4.5 of Attachment B);

(i) the contractor shall be responsible for coverage until the last day of the calendar month of admission; and

(ii) upon the entering an admission record with the Department, the Enrollee will disenroll from the Contractor's plan for subsequent months;

(5) applied behavioral analysis services;

(6) Waiver Services:

(i) Home and Community Based Waiver Services for Individuals 65 or Older;

(ii) Home and Community Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older;

(iii) Community Supports Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions;

(iv) Home and Community Based Waiver Services for Individuals with Physical Disabilities;

(v) Home and Community Based Waiver Services - New Choices Waiver;

(vi) Home and Community Based Waiver Services for Technology Dependent, Medically Fragile Individuals;

(vii) Home and Community Based Waiver Services under the Community Transitions Waiver; and

(viii) Home and Community Based Waiver Services under the Medically Complex Children's Waiver;

(7) specialized mental health services. Treatment for mental health conditions is a covered service when done by a Primary Care Provider. Mental health conditions may be handled by the Contractor's Primary Care Providers or referred to the Enrollee's Prepaid

Mental Health Plan when more specialized services are required for the Enrollee. (See Article 4.10 of Attachment B);

(8) substance use disorder services are carved out except for the service(s) specified in Article 1.3.21 of this attachment;

(9) specific classes of drugs:

(i) transplant immunosuppressive drugs;

(ii) attention deficit hyperactivity disorder stimulant drugs;

(iii) antipsychotic drugs;

(iv) antidepressant drugs;

(v) antianxiety drugs;

(vi) anticonvulsant drugs;

(vii) hemophilia drugs; and

(viii) the following substance use disorder treatment drugs and their associated generics (if any) indicated for the same uses:

(a) Vivitrol®;

(b) Revia®;

(c) Suboxone®;

(d) Campral®; and

(e) Antabuse®.

(10) methadone (including the medication and administration of the medication) by a licensed opioid treatment program [OTP]);

(11) non-emergency transportation;

(12) mental health evaluations and psychological testing performed for:

(i) mental health and substance use disorders.

(ii) physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual disabilities, developmental disorders, or organic disorders. However, psychiatric consultations that are performed for Enrollees admitted for a Contractor-authorized inpatient hospitalization for a covered diagnosis are the Contractor's responsibility;

(13) services provided by an Indian Health Services (IHS), Tribal or Urban Indian Organization (UIO) facility;

(14) early intervention services;

(15) school-based skills development program services;

(16) chiropractic services;

(17) services provided at the Utah State Hospital;

(18) services provided at the Utah State Developmental Center;

(19) apnea monitors;

(20) drug testing for substance use disorder treatment when performed by an independent lab;

(21) Ultra High Cost Drugs;

(i) Qualifying drugs shall be listed and updated via the Utah Medicaid Preferred Drug List (PDL) and via the PDL-Plus file.

(ii) Administration is to be covered by the Contractor; and

(22) consultation provided by a psychiatrist to an Enrollee's treating physician. For reimbursement the psychiatrist must bill their services FFS using the codes that are in the Telepsychiatry section of the Utah Medicaid Provider Manual.

1.2.1 Special Rules for Oxygen Concentrators

The Contractor is responsible for payment of oxygen concentrators for Enrollees living in counties with mandatory enrollment in Health Plans as specified in the Service Area section of Article 2 of Attachment B.

1.2.2 Special Rules for Enrollees dually eligible for Medicare Part D

The Contractor is not required to cover benzodiazepines or barbiturates for Enrollees who are dually eligible for Medicare Part D.

1.3 Covered Services

1.3.1 Covered Services, General Requirements

Attachment C lists broad categories of Covered Services.

1.3.2 Inpatient Hospital Services

Services furnished in a licensed, certified hospital are Covered Services.

1.3.3 Outpatient Hospital Services

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital are Covered Services.

1.3.4 Emergency Department Services

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

1.3.5 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are Covered Services.

1.3.6 General Preventative Services

Preventative services such as mammograms, Pap smears, prostate exams, and preventative exams for adults are Covered Services.

1.3.7 Vision Care

(A) Services provided by licensed ophthalmologists, licensed optometrists, and opticians within their scope of practice are Covered Services.

(B) Covered Services for vision include, but are not limited to, the following:

(1) eye examinations and care to identify and treat medical problems;

(2) eye refractions, examinations;

(3) laboratory work;

(4) lenses;

(5) eyeglass frames;

(6) repair of frames;

(7) repair or replacement of lenses; and

(8) contact lenses when Medically Necessary.

(C) Eyeglasses including frames, lenses and contacts are Covered Services for EPSDT and pregnant Enrollees.

1.3.8 Laboratory and Radiology Services

(A) Professional and technical laboratory and X-ray services furnished by licensed and certified Providers are Covered Services.

(B) All laboratory testing sites, including physician office labs, providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

(C) Those laboratories with certificates of waiver shall provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

1.3.9 Physical Therapy

(A) Treatment and services provided by a licensed physical therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

1.3.10 Occupational Therapy

(A) Treatment and services provided by a licensed occupational therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Occupational Therapy services provided in the home are available only to EPSDT and pregnant Enrollees.

1.3.11 Speech and Hearing Services

(A) Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss are Covered Services for Enrollees Eligible for EPSDT.

(B) Speech and language services are Covered Services for Enrollees eligible for EPSDT. For Enrollees who are not eligible for EPSDT, speech and language services are not Covered Services unless provided as part of an acute inpatient hospital stay, as outpatient therapy in an acute hospital owned and operated by the acute hospital, or at a FQHC.

(C) Audiology and hearing services including hearing aids and batteries are Covered Services for EPSDT Enrollees.

(D) Speech augmentative communication devices (SACDs) are a Covered Service for EPSDT Eligible Enrollees. SACDs are a Covered Service for Enrollees who are not eligible for EPSDT if the SACD(s) is Medically Necessary.

(E) Hearing evaluations or assessments for hearing aids are covered. Hearing aids covered only if hearing loss is congenital for EPSDT.

1.3.12 Podiatry Services

Services provided by a licensed podiatrist are Covered Services.

1.3.13 End Stage Renal Disease—Dialysis

Treatment of end stage renal dialysis for kidney failure is a Covered Service. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.3.14 Hemophilia and Blood Clotting Disorder

Hemophilia and Blood Clotting Disorder Disease Management Services are covered services.

1.3.15 Home Health Services

(A) Home health services are defined as part-time intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound are Covered Services. Home Health Services are based on a physician’s order and plan of care.

(B) Home health care shall be rendered by a Medicare-certified home health agency.

(C) The Contractor agrees to comply with all federal regulations regarding surety bonds. The Contractor agrees to contract with only Medicare-certified Home Health Agencies who carry a surety bond if federal regulations regarding this requirement are reinstated. The Department agrees to notify the Contractor if such federal regulations are reinstated.

(D) Personal care services as defined in the Department’s Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

1.3.16 Hospice Services

(A) Services delivered to terminally ill patients (six-month life expectancy) who elect palliative versus aggressive care are Covered Services. EPSDT Enrollees may elect to receive both palliative and aggressive care.

(B) Hospice care shall be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR or freestanding hospice facility, the Contractor is responsible for up to 30 calendar days of hospice care.

1.3.17 Private Duty Nursing

(A) Services provided by licensed nurses for ventilator-dependent individuals in their home as an alternative to hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home are Covered Services.

(B) Requests for continuous care shall be evaluated on a case-by-case basis and shall be approved by the Contractor.

1.3.18 Medical Supplies and Medical Equipment

(A) Medical supplies and medical equipment are Covered Services which include any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to their best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but shall be ordered by a physician.

(B) Durable medical equipment (DME) which are considered Covered Services, includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies shall be provided by a DME supplier that has a surety bond. Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-70, with the exception of criteria concerning long term care since long term care services are non-covered services under the Contract.

1.3.19 Abortions and Sterilizations

(A) Abortions are covered only under the following conditions specified in the Federal Hyde Amendment:

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising

from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(B) Sterilizations are Covered Services to the extent permitted by federal and State law.

(C) Both abortions and sterilizations shall meet the documentation requirement of 42 CFR § 441, subparts E and F. These requirements shall be met regardless of whether Medicaid is primary or secondary payer.

1.3.20 Transgender Services

The Contractor shall follow the Department's policy in the delivery of transgender services.

1.3.21 Treatment for Substance Use

Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

1.3.22 Organ Transplants

(A) The following transplantations are Covered Services for all Enrollees unless amended under the provisions of Article 4.8 of Attachment B:

(1) bone marrow;

(2) combined heart/lung;

(3) combined intestine/liver;

(4) combined kidney/pancreas;

(5) combined liver/kidney;

(6) combined liver/small bowel;

(7) cornea;

(8) heart;

(9) intestine;

(10) kidney;

(11) liver;

(12) lung;

(13) multi visceral;

(14) pancreas;

(15) small bowel; and

(16) stem cell.

(B) Medical costs for the donor are only covered if the donor is Medicaid eligible.

1.3.23 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, freestanding ambulatory surgical centers and Birthing Centers.

1.3.24 Skilled Nursing Facility, Intermediate Care Facility (ICF or ICF-ID) and Long Term Acute Care Stays 30 Days or Less

(A) The Contractor shall provide care for Enrollees in skilled nursing facilities, Intermediate Care Facilities (ICF or ICF-ID), and Long Term Acute Care (LTAC) hospitals requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within 30 calendar days or less.

(B) When the prognosis of an Enrollee indicates that the facility stay will be for more than 30 days, the Contractor shall provide coverage until the last day of the calendar month of admission. Upon the facility entering an admission record with the Department, the Enrollee will disenroll from the Contractor's plan for subsequent months.

(C) Skilled nursing care is to be rendered in a facility which meets federal regulations of participation.

1.3.25 Services to EPSDT Enrollees

(A) The Contractor shall provide to EPSDT Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.

(B) The Contractor is not responsible for providing home and community-based services available through Utah's Home and Community-Based waiver programs.

(C) The Contractor shall provide the full EPSDT services to all eligible EPSDT Enrollees in accordance with the periodicity schedule as described in the Utah EPSDT Provider Manual.

(D) The Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the EPSDT periodicity schedules, including policies for Participating Providers to screen all members between six months and 72 months for blood lead levels. These policies and procedures shall emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the EPSDT Enrollees.

1.3.26 Family Planning Services

(A) Family Planning Services are covered Services. Family Planning Services includes disseminating information, counseling, and treatments relating to family planning services.

(B) Family Planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law.

(C) Birth control services include information and instructions related to the following:

(1) birth control pills;

(2) Norplant (removal for traditional only);

(3) Depo Provera;

(4) IUDs;

(5) barrier methods including diaphragms, male and female condoms, and cervical caps;

(6) vasectomy or tubal ligations;

(7) NuvaRing®; and

(8) office calls, examinations, or counseling related to contraceptive devices.

1.3.27 High-Risk Prenatal Services

(A) The Contractor shall ensure that high-risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate Provider or facility.

(B) In the determination of the Provider and facility to which a high-risk prenatal Enrollee shall be referred, care shall be taken to ensure that the Provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling shall be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

(C) Enrollees who are pregnant shall be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not

be moderate or high risk shall be evaluated for change in risk status throughout their pregnancy.

(D) The Contractor shall have a mechanism to assure that prenatal care Providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care Providers shall be consistent with standards of practice and linked to the Contractor's care coordination/case management programs for those Enrollees who have a moderate or high-risk status. All prenatal health care Providers shall be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy.

(E) The Contractor's healthy pregnancy programs shall also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The Contractor shall refer to and coordinate care with the prenatal care Providers concerning the treatment plan and risk factors. The Contractor's risk assessments shall be overseen by the Contractor's Medical Director.

(F) Assessment tools used by prenatal care Providers and the Contractor shall include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the Contractor and prenatal care Providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care.

(G) The Department recommends Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The Department recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk shall receive care coordination/case management services.

(H) The Department recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on:

(1) evidence of clinical hepatitis during pregnancy;

(2) injection drug use;

(3) occurrence during pregnancy or a history of STDs; or

(4) judgment of the health care Provider.

(I) When a woman is found to be HBsAg-positive, the Contractor shall provide HBIG and HB vaccine at birth. Initial treatments shall be given during the first 12 hours of life. The Contractor shall comply with all other requirements as specified in Utah Administrative Code R386-702-9.

(J) The Department recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Health Code 26-6-20. Testing for STDs shall be repeated in the 3rd trimester for Enrollees at high risk for exposure.

(K) The Department also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The Contractor shall encourage Providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to:

(1) universal testing with an opt-out approach (testing of all pregnant Enrollees and not just those who appear to be at high risk for HIV;

(2) flexibility in the consent process; and

(3) prevention and referral through education during prenatal care.

(L) Prenatal care Providers shall have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy shall be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive shall receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns.

(M) Prenatal services provided directly or through agreements with appropriate Providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant Enrollees:

(1) perinatal care coordination (T1017).

(2) prenatal and postnatal home visits.

(3) group prenatal and postnatal education.

(4) nutritional assessment and counseling.

(5) prenatal and postnatal psychosocial counseling.

(N) Psychosocial counseling is a service designed to benefit the pregnant Enrollee by helping them cope with the stress that may accompany their pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant Enrollees

who are also suffering from a serious emotional or mental illness shall be referred to an appropriate mental health care Provider.

1.3.28 Services for Children with Special Health Care Needs

(A) In addition to Primary Care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care shall be provided in a timely manner. The specialized care shall comprehensively address all areas of need to be most effective and shall be coordinated with Primary Care and other services to be most efficient. The children's families shall be involved in the planning and delivery of the care for it to be acceptable and successful.

(B) All children with special health care needs shall have timely access to the following services:

(1) Comprehensive evaluation for the condition.

(2) Pediatric subspecialty consultation and care appropriate to the condition.

(3) Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

(4) Durable medical equipment appropriate for the condition.

(5) Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

(C) In addition, children with the conditions marked by * below shall have timely access to coordinated multispecialty clinics, when Medically Necessary, for their disorder.

(D) The definition of children with special health needs includes, but is not limited to, the following conditions:

(1) Nervous System Defects such as:

(a) Spina Bifida*.

(b) Sacral Agenesis*.

(c) Hydrocephalus.

(2) Craniofacial Defects such as:

(a) Cleft Lip and Palate*.

(b) Treacher - Collins Syndrome.

(3) Complex Skeletal Defects such as:

(a) Arthrogryposis*.

(b) Osteogenesis Imperfecta*.

(c) Phocomelia*.

(4) Inborn Metabolic Disorders such as:

(a) Phenylketonuria*.

(b) Galactosemia*.

(5) Neuromotor Disabilities such as:

(a) Cerebral palsy*.

(b) Muscular Dystrophy*.

(c) Complex Seizure Disorders.

(6) Congenital Heart Defects.

(7) Genetic Disorders such as:

(a) Chromosome Disorders.

(b) Genetic Disorders.

(8) Chronic Illnesses such as:

(a) Cystic Fibrosis.

(b) Hemophilia.

(c) Rheumatoid Arthritis.

(d) Bronchopulmonary Dysplasia.

(e) Cancer.

(f) Diabetes.

(g) Nephritis.

(h) Immune Disorders.

(9) Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with intellectual disability.

(E) The Contractor agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The Contractor further agrees to cooperate

with the Department‘s quality assurance monitoring for this population by providing requested information.

1.3.29 Medical and Surgical Services of a Dentist

(A) Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

(B) Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

(C) The Contractor is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the Enrollee requires services at a lesser level, the Provider shall refer the Enrollee to a dentist for treatment. If the dental-related problem is serious enough for the Enrollee to be admitted to the hospital, the Contractor is responsible for coverage of the inpatient hospital stay.

(D) The Contractor is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

(E) The Contractor is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

(F) The Contractor is responsible for anesthesia associated with a Covered Service.

1.3.30 Diabetes Education

(A) The Contractor shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

(1) has recently been diagnosed with diabetes;

(2) is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee’s self-management plan; or

(3) is determined by the health care professional to require re-education or refresher training.

1.3.31 Human Immunodeficiency Virus (HIV) Prevention

(A) The Contractor shall have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) shall be culturally and linguistically appropriate. All Enrollees shall be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from State of Utah-operated programs.

(B) Special attention shall be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

1.3.32 Pharmacy

The Contractor shall cover all prescribed drugs as outlined in Attachment B that the State Plan covers with the exception of the classes of drugs specifically listed in this Contract as being carved out.

1.3.33 Dental Fluoride Varnish

Application of dental fluoride varnish for children birth through 4 years as part of a well-child (EPSDT) exam is a covered service.

1.3.34 Autism Spectrum Disorder Services

Autism Spectrum Disorder Services are Covered Services only to the extent as outlined in the Utah Autism Spectrum Disorder Services Provider Manual.

1.3.35 Qualifying Clinical Trials

(A) Pursuant to Section 210 of the Consolidated Appropriations Act of 2021, the Contractor shall cover routine patient costs for an Enrollee participating in a Qualifying Clinical Trial.

(1) Routine Enrollee costs include any item or service provided to an Enrollee under the Qualifying Clinical Trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from such participation, to the extent that the provision of such an item or service to the Enrollee outside the course of such participation would otherwise be covered under the State plan or waiver; and

(2) any item or service required solely for the provision of the investigational item or service that is the subject of such trial, including the administration of such investigation item or service.

(B) The Contractor shall not be responsible for an item or service that is the investigational item or service that is:

(1) the subject of the Qualifying Clinical Trial; and not otherwise covered outside of the clinical trial under the State Plan or waiver; or

(2) is an item or service that is provided to the Enrollee solely to satisfy data collection and analysis needs for the Qualifying Clinical Trial and is not used in the direct clinical management of the Enrollee; and not otherwise covered under the State plan or waiver.

(C) A determination of coverage for an Enrollee participating in a Qualifying Clinical Trial shall:

(1) be expedited and completed within 72 hours;

(2) be made without limitation on the geographic location or network affiliation of the Provider treating such Enrollee or the principal investigator of the Qualifying Clinical Trial;

(3) be based solely on attestation regarding the appropriateness of the Qualifying Clinical Trial by the Provider and principal investigator described in Article 1.3.35(C)(2) of this attachment, which shall be made using a streamlined, uniform form developed for national use by the Secretary of HHS and that includes the option to reference information regarding the Qualifying Clinical Trial that is publicly available on a website maintained by the Secretary, such as clinicaltrials.gov (or a successor website); and

(4) not require submission of the protocols of the Qualifying Clinical Trial, or any other documentation that may be proprietary or determined by the Secretary of HHS to be burdensome to provide.

Article 2: Cost Sharing

2.1 Cost Sharing Provisions

2.1.1 Cost Sharing, Generally

(A) The Contractor shall ensure that cost sharing (copayments and coinsurance) required of Enrollees are consistent with the Department's cost sharing payment rules and policies.

(B) The Contractor shall not charge cost sharing to Enrollees who have been determined by the Department to have met their out of pocket monthly maximum. Enrollees may request that their cost sharing be reviewed by the Department to determine whether the Enrollee has met their out of pocket monthly maximum amount. The Contractor shall refer any Enrollee seeking such a determination to the Department's Health Program Representatives.

2.1.2 Family Planning Copayments

Services and prescription drugs related to family planning are Excluded from all copayment and coinsurance requirements.

2.1.3 Special Rule for American Indian Copayments

The Contractor shall comply with the copayment and coinsurance requirements for American Indians as stated in Section 5006 of the American Recovery and Reinvestment Act of 2009.

2.1.4 Special Rules for Pharmacy Copayments

Each Enrollee must pay a copayment of $4.00 per prescription. The maximum copayment to be charged by the ACO is $12.00 per Enrollee per month.

2.1.5 Services with Cost Sharing

(A) Enrollees who have cost sharing requirements are responsible to pay copayments for the following services:

(1) non-emergency use of the emergency room;

(2) inpatient hospital stays;

(3) pharmacy;

(4) physician, except as excluded in Article 2.1.6(A)(5) of this attachment;

(5) podiatry;

(6) outpatient hospital; and

(7) ophthalmologists.

2.1.6 Services without Cost Sharing

(A) The following services are excluded from cost sharing requirements:

(1) services and prescription drugs related to family planning;

(2) immunizations;

(3) preventive services;

(4) laboratory services;

(5) radiology services;

(6) evaluation and management (E/M) services performed for the purpose of providing psychiatric medication management;

(7) some nursing home stays; and

(8) dental, except emergency dental services.

2.1.7 Enrollees Exempt from Cost Sharing

(A) The following Enrollees are exempt from all cost sharing requirements:

(1) American Indians;

(2) Alaska Natives;

(3) pregnant Enrollees;

(4) individuals eligible for EPSDT;

(5) individuals receiving hospice services;

(6) individuals in the Medicaid cancer program; and

(7) individuals whose total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families (TANF) standard payment allowance.

Attachment D - Quality and Performance

Article 1: Quality Assessment and Performance Improvement Program

1.1 Quality Assessment and Performance Improvement, Generally

(A) Pursuant to 42 CFR § 438.330, the Contractor shall have an ongoing comprehensive QAPIP for the services it furnishes to its Enrollees.

(B) The QAPIP shall include a policymaking body that oversees the QAPIP. A designated senior official shall be responsible for administration of the program. The QAPIP shall include an interdisciplinary quality assessment and performance improvement committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body, and other functional areas of the organization.

(C) The Contractor agrees that CMS, in consultation with states and other stakeholders, may specify performance measures and topics for PIPs that would be required for the Contractor to implement.

1.2 Basic Elements of Quality Assessment and Performance Improvement Programs

(A) At a minimum, the Contractor shall establish and maintain a QAPIP that includes at least the following elements:

(1) PIPs in accordance with Article 1.4 of this attachment;

(2) collection and submission of performance measurement data in accordance with Article 1.5 of this attachment;

(3) mechanisms to detect both underutilization and overutilization of services;

(4) mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs as defined in the Department's Managed Care Quality Strategy; and

(5) a process for evaluating the impact and effectiveness of its QAPIP.

1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Article 1.1 and Article 1.2 of this attachment.

(B) The Contractor shall submit its written QAPIP description to the Department by February 1, 2023, or a mutually agreed upon date. In subsequent years of the contract, the Contractor shall submit to the Department its QAPIP description if it has changed from the last submission.

(C) The Contractor shall annually submit the following QAPIP-related documents to the Department in a Department-specified format:

(1) The Contractor's quality improvement work plan for the current calendar year;

(2) The Contractor's performance measurement on HEDIS and CAHPS rates; and

(3) The Contractor's quality improvement work plan evaluation for the previous calendar year.

(D) The Contractor shall submit its QAPIP-related documents to the Department by February 1 or a mutually agreed upon date each year.

1.4 Performance Improvement Projects

(A) The Contractor shall have ongoing PIPs that focus on clinical and nonclinical areas, including any PIPs required by CMS or the Department.

(B) Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and that include:

(1) measurement of performance using objective quality indicators;

(2) implementation of interventions to achieve improvement in the access to and quality of care;

(3) evaluation of effectiveness of the interventions based on the performance measures specified in Article 1.4(B)(1) of this attachment; and

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

(C) Before implementing a new PIP, the Contractor shall submit the topic to the Department for approval using a format specified by the Department.

(D) The Contractor shall report the status and results of each PIP, including those required by CMS, to the Department as requested by the Department, but no less than once per year.

(E) The Contractor agrees that the Department may, at its discretion, establish a timeframe and deadline for the Contractor to complete a PIP.

1.5 Performance Measurement

(A) 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 develop and implement a written plan for each quality measure currently below the national average.

(C) The Contractor shall compile and submit to the Office of Research & Evaluation (ORE):

(1) audited HEDIS for the preceding calendar year by July 1 of each year as set forth in Utah Administrative Code R428-13-1, et seq; and

(2) CAHPS survey data as set forth in Utah Administrative Code R428-12-12-1 et seq.

(D) Data, calculations for HEDIS and CAHPS, and results of standard measures shall include all Enrollees.

Article 2: Quality Tracking and Monitoring

2.1 Quality Measures

(A) The Contractor agrees that the Department may amend the quality measures found in Article 2.2 of this attachment. 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.

(B) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

2.2 Quality Measures Table

Population	Measure	Condition
(A) Maternity Care		
(1)	Prenatal and Postpartum Care Rate (PPC2-CH)	Preventive Services

(2)	Prenatal and Postpartum Care Rate (PPC2-AD)	Preventive Services
(B) Newborn/ Infant Care		
(1)	Childhood Immunization Status - Combo 3 (CIS)	Preventive Services
(2)	Well-Child Visits in the First 30 Months of Life (W30)	Preventive Services
(C) Pediatric Care		
(1)	Immunizations for Adolescents (IMA Combo 2)	Preventive Services
(2)	Child and Adolescent Well-Care Visits (WCV)	Preventive Services
(3)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Assessment (WCC)	Preventive Services
(4)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Acute Care
(5)	Getting Needed Care (Child CAHPS) (annually)	Access
(6)	Getting Care Quickly (Child CAHPS) (annually)	Access
(7)	Customer Service (Child CAHPS) (annually)	Access
(8)	How Well Doctors Communicate (Child CAHPS) (annually)	Access
(9)	Satisfaction with Health Care (Child CAHPS) (annually)	Satisfaction
(10)	Satisfaction with Health Plan (Child CAHPS) (annually)	Satisfaction
(11)	Satisfaction with Personal Doctor (Child CAHPS) (annually)	Satisfaction
(12)	Satisfaction with Specialist (Child CAHPS) (annually)	Satisfaction
(D) Adult Care		
(1)	Breast Cancer Screening (BCS)	Preventive Services
(2)	Cervical Cancer Screening (CCS)	Preventive Services
(3)	Access to Ambulatory Care (AAP)	Preventive Services

(4)	Use of Imaging for Low Back Pain (LBP)	Acute Care
(5)	Antidepressant Medication Management (AMM)	Acute Care
(6)	Hemoglobin A1c Control for Patients with Diabetes (HBD)	Chronic Care
(7)	Eye Exam for Patients with Diabetes (EED)	Chronic Care
(8)	Controlling High Blood Pressure (CBP)	Chronic Care
(9)	Getting Needed Care (Adult CAHPS) (annually)	Access
(10)	Getting Care Quickly (Adult CAHPS) (annually)	Access
(11)	Customer Service (Adult CAHPS) (annually)	Access
(12)	How Well Doctors Communicate (Adult CAHPS) (annually)	Access
(13)	Satisfaction with Health Care (Adult CAHPS) (annually)	Satisfaction
(14)	Satisfaction with Health Plan (Adult CAHPS) (annually)	Satisfaction
(15)	Satisfaction with Personal Doctor (Adult CAHPS) (annually)	Satisfaction
(16)	Satisfaction with Specialist (Adult CAHPS) (annually)	Satisfaction

2.3 Quality Measure Corrective Actions

In the event that the Contractor's quality measure performance is not at or above the national average as required by this Article, the Contractor may be subject to the corrective actions found in Article 14 of Attachment B.

Article 3: External Quality Review

3.1 External Quality Review, Generally

(A) Pursuant to 42 CFR § 438, subpart E, the Department shall arrange for EQRs to annually analyze and evaluate aggregated information on quality, timeliness, and access to Covered Services in accordance with 42 CFR § 438.358(b)(1)(i) through 438.358(b)(1)(iv).

(B) The Contractor shall maintain, and make available to the EQRO, all clinical and administrative records for use in EQRs.

(C) The Contractor shall develop a corrective action plan to comply with the EQRO's required corrective actions.

(D) The Contractor shall act in good faith to implement other recommendations resulting from the analysis required in Article 3.1(A) of this attachment.

(E) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

3.2 Contractor Staffing Requirements

(A) The Contractor shall designate an individual to serve as a liaison for the EQRs.

(B) The Contractor shall designate representatives, as needed, including but not limited to a quality improvement representative and a data representative to assist with EQRs.

3.3 Copies and On-Site Access

(A) The Contractor shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during reviews.

(B) Document copying costs are the responsibility of the Contractor.

(C) Enrollee information includes, but is not limited to, medical records, administrative data, Encounter Data, and Claims data, maintained by the Contractor or its Network Providers.

(D) Onsite EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate workspace, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Contractor shall assign appropriate staff to assist during EQRs.

(G) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

3.4 Timeframe for Providing Information

(A) The Contractor shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by the Department.

(B) If the Contractor cannot meet the timeframe for providing documentation, the Contractor shall request an extension from the Department. It shall be the discretion of the Department to approve or disapprove the extension.

Article 4: Miscellaneous Quality Provisions

4.1 Accrediting

(A) The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.

(B) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide the Department a copy of its most recent accreditation review 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: Comprehensive Risk Contract

1.1 Comprehensive Risk Contracts, Generally

(A) This Contract is classified as a Comprehensive Risk Contract except for the Risk Corridor, as described in Article 3 of this attachment.

(B) The Contractor shall provide all services required by this Contract.

(C) The Capitation Payments, any cost sharing from Enrollees, and any supplemental payments made by the Department to the Contractor, shall be considered payment in full for all services covered under this Contract.

(D) The Contractor incurs loss if the cost of furnishing the services exceeds the payments under this Contract except as outlined in Article 3.1 of this attachment.

(E) The Contractor may retain all Capitation Payments made by the Department, unless Article 2.6 of this attachment applies, and shall use them for Enrollees.

(F) The Contractor may retain all payments made by the Department under this Contract except as outlined in Article 2.5, Article 2.6, and Article 3.1 of this attachment.

(G) Pursuant to 42 CFR § 438.3(e), the Contractor may provide services to Enrollees that are in addition to those covered under the State Plan. The cost of these services cannot be included when determining rates.

(H) Capitation Payments may only be made by the Department and retained by the Contractor for Medicaid Eligible Enrollees.

(I) The Contractor shall report to the Department within 60 calendar days when it has identified a Capitation Payment or other payments in excess of the amounts specified in this Contract.

Article 2: Payments

2.1 Payment Schedule

(A) The Department shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the Department's 820 Enrollment Report, regardless of whether the Enrollee receives a Covered Service during that month Separate Capitation Rates for each eligibility group or Capitation Rate Cell are in Article 2.2 of this attachment.

(B) The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, the Department reserves the right to amend the Capitation Rates to reflect the change in funding. The Department shall notify the Contractor of any change in the Capitation Rates due to a loss of funding. When possible, the Department shall make reasonable efforts to notify the Contractor at least 30 calendar days prior to the change in Capitation Rates. In the event of a change in Capitation Rates pursuant to a loss of funding, if the Contractor determines that the new rates are unacceptable, the Contractor may terminate this Contract after it provides 60 calendar days written notice of intent to terminate to the Department. If the Contractor elects to terminate the Contract pursuant to Article 2.1(B) of this attachment this shall not be considered a default under the Contract.

2.2 Capitation Rates – Legacy Medicaid Population

Capitation Rates Effective July 1, 2024 - June 30, 2025

Rate Cell	Description	Capitation Rate Less 2% withhold	Capitation Rate Inclusion of 2% withhold
A	Male (1-18 &19-20 IL)	$194.17	$196.23
B	Male (19-64 years)	$652.66	$659.58
C	Female (1-18 & 19-20 IL)	$196.58	$198.68
D	Female (19-64 years)	$768.12	$776.49
E	Aged, Non-Dual (65 years and older)	$1,555.88	$1,571.96
F	Technology Dependent Waiver	$19,602.04	$19,857.80
G	Disabled Male (all ages)	$1,209.50	$1,223.86
H	Disabled Female (all ages)	$1,261.92	$1,276.26
I	Medically Needy Child	$272.23	$275.17
K	Male (birth to 1 year)	$1,780.14	$1,797.37
L	Female (birth to 1 year)	$1,428.37	$1,442.11
M	Aged, Dual (65 years and older)	$247.48	$249.86
N	Breast/Cervical Cancer (all ages)	$4,906.40	$4,963.53
P	Pregnant Woman (all ages)	$552.29	$558.08
Q	Restriction (formerly NT)	$3,533.98	$3,570.53
R	Traditional Restriction (all ages)	$4,965.36	$5,016.24
MCR	Maternity Case Rate	$7,698.19	$7,855.30

2.3 Delivery Case Rate – Legacy Medicaid Population

The Department shall reimburse the Contractor a Delivery Case Rate per delivery when the delivery occurs at 22 weeks or later, regardless of viability. The Delivery Case Rate is intended to include all Medically Necessary inpatient and physician expenditures associated with the delivery. The Delivery Case Rate does not include expenses associated with prenatal care. The Delivery Case Rate is in addition to the monthly Capitation Rate for the Enrollee for eligible

enrollees. The Contractor must submit Encounter Data, which include incurred claim costs directly related to the Enrollee's labor and delivery and paid by the Contractor, in order to receive the Delivery Case Rate payment from the Department.

2.4 Capitation Rates – Adult Expansion Population

Capitation Rates Effective July 1, 2024 - June 30, 2025

Rate Cell	Description	Capitation Rate
J	Expansion Parent Male 19-34	$257.46
O	Expansion Parent Male 35-64	$559.31
S	Expansion Parent Female 19-34	$486.90
T	Expansion Parent Female 35-64	$943.01
U	Expansion Non-Parent Male 19-34	$378.25
V	Expansion Non-Parent Male 35-64	$1,354.47
W	Expansion Non-Parent Female 19-34	$513.31
X	Expansion Non-Parent Female 35-64	$1,418.45
Y	Restriction Parent-Expansion Adult	$3,710.43
Z	Restriction Non-Parent-Expansion Adult	$3,902.42

2.5 Payment Procedures

(A) The Department shall make payments to the Contractor through its Provider Reimbursement Information System for Medicaid (PRISM) for all Enrollees under this Contract.

(B) Unless a sanction provision found in Attachment B applies, the Department shall pay the Contractor the Capitation Rates designated in Article 2.2 and Article 2.4 of this attachment for all current Enrollees listed in the Department's 820 payment file.

(C) On a weekly basis, the Department shall provide the Contractor with the following reports:

(1) a Payroll Deducted and Other Group Premium Payment for Insurance Products (820) report that includes identifying information on all Enrollees for which the Department has paid a Capitation Rate; and

(2) an 820 report that contains summary aggregate information of the count of Enrollees by month and Capitation Rate Cell.

2.6 Payment Adjustments

(A) If the Contractor believes an error in Capitation Payment has been made by the Department, the Contractor shall notify the Department in writing within 60 calendar days.

The Contractor shall supply supporting documentation for the Department's review. If appropriate, the Department shall adjust the Contractor's Capitation Payment.

(B) The Department shall automatically adjust Capitation Rates when an Enrollee's aid category is changed retroactively. The Department shall transmit this information to the Contractor via the Eligibility Transmission.

2.7 High Cost Drug Funding Allocation

(A) Drugs eligible for reimbursement from the High Cost Drug Reimbursement pool include the following criteria:

(1) The drug is covered by Utah Medicaid.

(2) The total drug expenditure for the drug must equal or exceed $240,000 in the SFY.

(3) The End Date of Service falls within the SFY.

(4) The Claim is paid by the ACO before October 31, following the SFY.

(5) The applicable Encounter record is accepted by the Department by December 15, following the end of the SFY.

(6) The drug is identified by the Department as new to market in the previous three years. An established drug (on market for over three years) that has a new indication would not qualify.

(7) New drugs introduced during the high-cost drug review period are eligible for reimbursement when they meet the criteria listed above. (A specific list of drugs will not be created prior to the beginning of the calendar year; rather, the included drugs shall be those meeting the criteria noted herein.).

(8) Exclusions:

(i) Hepatitis C and Cystic Fibrosis drugs are not included.

(B) Eligible Expenses

(1) Expenses eligible for payment are those where the expense is directly related to the drug that has been identified as eligible and the expense was incurred during the fiscal year.

(2) Drug expenses originating from both retail pharmacies and medical Providers (e.g., facilities, clinics, physician offices, etc.) will be included.

(3) Expenses will be based on the amount paid by the Health Plan as recorded in the Claim.

(4) Institutional Claims having drugs meeting the criteria shall be separately identified by each ACO and reported to the Reimbursement Unit for validation.

(C) Retrospective Reimbursement Methodology

(1) Quarterly estimate calculation.

(i) On a quarterly basis, the Department will send a report to the Contractor with total expenses for drugs meeting the criteria to all ACOs.

(a) Anticipate sending prior quarter data at the end of subsequent quarter. For example, June 30 will send data for January-March service dates.

(b) These estimates will use an annualizing-like factor. For example, in Q1, if there is spend greater than $60,000, then the drug/member will be included, etc.

(ii) On a quarterly basis, the Department will send a detailed report of drugs meeting the criteria to each ACO with their claims.

(iii) The quarterly reports are to provide expense estimates to the Health Plans for expenses that may potentially meet eligibility at the end of the year. The quarterly reports are estimates only and will not be paid to the Health Plans.

(iv) The Department will base the reports on the encounter data submitted by the plans and accepted by the Department. The Health Plans shall not submit other reports to be considered with the following exception:

(a) Institutional Claims, which cannot be easily dissected to determine if high cost drugs are included, shall be identified by the ACO.

(b) The ACO shall submit a report by the end of the second month of the following quarter, each quarter detailing the institutional Claims identified and the specific amount of “high-cost” attributed to the Claim along with the NDC of the drug. For example, January through March institutional Claims shall be reported by May 31, etc.

(c) The Department will include the institutional Claims that can be validated as meeting the inclusion criteria above.

(2) Annual Report and Payment.

(i) Eligible annual expenses will be based on the following criteria:

(a) amount incurred during the applicable state fiscal year.

(b) paid on or before October 31, following the SFY.

(c) encounter data submitted and accepted by the Department no later than December 15, following the end of the SFY.

(ii) Reimbursement shall not exceed any ACO actual expenses.

(iii) Reimbursement shall not exceed the payment pool.

(iv) Remaining funds in the payment pool at the end of the year will not carry forward to the next year.

(v) A reimbursement percentage is calculated by dividing the total pool amount by the total amount of eligible expenses for all Health Plans for the SFY, with a maximum percentage of 100%. For example, if $8 million in expenses are eligible for reimbursement and $4 million is in the funding pool, all expenses would be reimbursed at a 50% level.

(vi) The reimbursement amount for each eligible expense is calculated as the reimbursement percentage multiplied by the eligible expense.

(vii) It shall be accepted that the sum of the quarterly estimates may differ from the final annual report.

(viii) Payments will be made based on the annual report and not the quarterly reports.

2.8 Capitation Rate Development

(A) Capitation Rates shall be developed using the Custom MARA OPTml model, calibrated on a paid basis for both the prospective and concurrent risk scores.

(B) Capitation Rates shall be developed on a prospective basis with a concurrent reconciliation.

Article 3: Risk Corridor - Adult Expansion Population

3.1 Risk Corridor Detail

(A) For the Adult Expansion Population, described in Article 2.4 of this attachment, an adjusted MLR shall be calculated from the MLR specified in Article 12.5 of Attachment B with the following adjustments:

(1) a risk adjustment based on the overall acuity of the Contractor's Enrollees will not be applied;

(2) directed payments will be removed from both the numerator and denominator;

(3) any credibility adjustment will be deducted; and

(4) the adjusted MLR is not presumed to meet or exceed the MLR calculation standards if it is non-credible.

(B) A Risk Corridor shall be established based on the following adjusted MLR threshold amounts:

(1) An adjusted MLR above 91% shall result in payment from the Department to the Contractor until the adjusted MLR equals 91%;

(2) An adjusted MLR between 85% and 91% shall result in no action; and

(3) An adjusted MLR less than 85% shall result in the Contractor reimbursing the Department until the adjusted MLR equals 85%.

(C) The Department shall complete a cost settlement within 180 calendar days after the MLR reporting due date as specified in Attachment B or another date mutually agreed upon in writing by the Contractor and the Department.

(D) If the Contractor is required to reimburse the Department:

(1) the payment shall be in the form of a check; and

(2) failure to make payment to the Department in full, within 30 calendar days of notification by the Department, may result in future Capitation Payments being withheld until the payment is received in full.

(E) If the Department is required to make payment to the Contractor, the Department shall make payment through a supplemental payment in a timely manner.

Attachment F - Quality Withhold and Rate Adjustments

Article 1: Quality Withhold and Rate Adjustments

1.1 Purpose of the Quality Withhold and Rate Adjustments

(A) The Parties agree and understand that the Department has established a quality withhold to support the following initiatives in the Managed Care Quality Strategy:

(1) Better Care through an annual evaluation of plan performance on ACO Quality Measures and the Non-ACO Quality Measures Table; and

(2) Better Health to promote preventive care for women and children.

(B) The Parties agree and understand that the quality withhold is subject to CMS approval consistent with federal regulations under 42 CFR § 438.

1.1.1 Goal of the Quality Withhold

(A) The Parties agree and understand that the goals of the quality withhold are to improve quality using the following measurement areas:

(1) Timely and accurate encounter data submission to support the outcome of quality reporting;

(2) Improvement on Healthcare Effectiveness Data and Information Set (HEDIS®) W30 (well-child visits in the first 15 and 15th to 30th months of life);

(3) Improvement on HEDIS® WCV (child and adolescent well-care visits for children 3-21 years of age);

(4) Improvement on HEDIS® CIS (childhood immunization status) combination 3; and

(5) Improvement on HEDIS® IMA (immunizations for adolescents) combination 2.

1.2 Quality Withhold Size

1.2.1 Quality Withhold Size

(A) The Department shall impose a quality withhold on Capitation Rates.

(B) The total quality withhold in SFY 2025 is comprised of 2% of the following (in SFY 2025 for services in SFY 2025).

(1) Contractor's SFY 2025 Risk-Adjusted Base Capitation Rates.

(2) Contractor's SFY 2025 Maternity Case Rate (MCR).

(3) Contractor's SFY 2025 Quality Expenses.

1.3 Measurements and Targets

1.3.1 Measure Overview

(A) The Contractor shall adhere to the contractual timelines to submit data, reports, or attestations and follow the guidance in the technical specification document for format, templates, and submission requirements.

(B) The Contractor shall earn the amount withheld based on the Contractor's performance in seven areas. Each measure corresponds to a portion of the amount withheld that may be earned based on achieving the target goals outlined in Article 1.1 of this attachment. Table 1 outlines the percentage of the amount withheld associated with each measure, which called the "measure share."

Table 1

Domain	Measure	Measure Share
Encounter Data	Encounter Data Timeliness and Accuracy	0.100%
Improvement on HEDIS® Measures	HEDIS® W30 - 0-15 Months	0.2375%
	HEDIS® W30 - 16-30 Months	0.2375%
	HEDIS® WCV	0.475%
	HEDIS® CIS	0.475%
	HEDIS® IMA	0.475%
Total		2.000%

Each measure is described in more detail in the following sections.

1.3.2 Encounter Data Timeliness and Accuracy

(A) Consistent with Article 1.3.1(B) of this attachment, the Contractor shall conduct an Encounter Data validation each quarter. To facilitate the validation, the Department shall send the Contractor an Encounter Data validation questionnaire and an Encounter Data submission detail file containing all accepted Encounter Data for the specified quarter that may be used for rate setting. The Department shall ensure that the same query used to supply Encounter Data to its actuary is used to prepare the submission detail file.

(B) Each quarter, the Contractor shall complete a timely validation process. Prior to each quarter, the Department shall evaluate the encounters that are rejected in PRISM. If rejections are based on PRISM errors, the Department will review the errors and may

suspend this requirement for that quarter. For each quarter that the requirement is suspended, the Contractor shall earn one quarter (.025%) of the total measure share of 0.1%.

(C) The Contractor's eligibility to earn the measure share for each quarter shall be determined on a pass/fail basis. If the Contractor requests to re-open a previously validated quarter, the Department shall consider the Contractor failed on that quarter's portion of the measure share and will forfeit the corresponding amount.

1.3.3 Encounter Data Timeliness and Accuracy Measurement Process

(A) The Department shall provide the Contractor a data set containing the same data used by the Department for the construction of the Medicaid data books within 45 days of the end of each quarter. The Department shall ensure that the quarterly data sets are run using the same query that is used to provide the data to the Department's contracted actuary.

(B) If the Contractor identifies missing data, the Contractor shall notify the Department of the missing data within 30 calendar days.

(i) If the missing data is due to failure of the Contractor to submit encounters, the Contractor shall be permitted to submit the missing data if it meets the requirements found in Article 12.3.1(E) of Attachment B and Article 12.3.1 of Attachment B.

(ii) If the missing data does not meet the requirements found in Article 12.3.1(E) of Attachment B and Article 12.3.1 of Attachment B, the Contractor shall still submit the data to the Department; however, it shall not be used for rate setting.

(iii) If the missing data is due to the Department not submitting the data in the quarterly data set, the Department shall provide the Contractor with a revised file for validation within 30 days of the missing data being identified. The Contractor shall have an additional 30 days to validate the revised data set.

(C) If an issue is identified including but not limited to issues that are outside of the control of the Contractor, errors in data extraction/submission by the Department, the Department may extend the timelines outlined in Article 1.3.3 of this attachment and shall confirm the extension in writing.

(D) The Contractor shall submit a written attestation to the Department that the data set delivered to the Contractor is complete and accurate.

1.3.4 Improvement on HEDIS® Measures

(A) For each of the five HEDIS® measures, the Department will determine the following values for the Contractor:

(1) The “Contractor base” is the Contractor’s prior year HEDIS® result as published in CY 2025.

(2) The "Contractor target" is the lower of:

(i) the nationwide average CY 2025 HEDIS® result as published in CY 2025; or

(ii) the "Contractor base" plus 5%.

(3) The "Contractor performance" is the Contractor's CY 2025 HEDIS® result as published in CY 2025.

(B) For each measure, the measure share shall be determined as follows:

(1) If the Contractor's performance is above the Contractor target, the Contractor shall earn the measure share applicable to the HEDIS® measure.

(2) If the Contractor's performance is below the Contractor base, the Contractor shall forfeit the measure share applicable to the HEDIS® measure.

(3) If the Contractor's performance is between the Contractor base and the Contractor target, the Contractor will earn a proportion of the measure share applicable to the HEDIS® measure equal to:

$$Contractor\ share\ earned\ = \frac{Contractor\ performance - Contractor\ base}{Contractor\ target - Contractor\ base}$$

(C) After the close of the fiscal year, the Department shall determine the total amount that the Contractor has earned by summing the earned measure shares.

(D) The Department will recoup and replace all capitation payments paid to the Contractor for services within the fiscal year.

(E) The replaced capitations will be the originally paid Risk-Adjusted Base Capitation Rates increased by the sum of the earned measure shares.

1.4 Final Determinations

The Department shall make all final determinations on Contractor performance and capitation withhold calculations, including the total amount withheld and earned based on the Contractor's performance. The Department shall work with the Contractor to address any disputes regarding whether or not the Contractor qualifies for any portion of the quality incentive pool. Department decisions are final and not subject to administrative appeal.