Utah Medicaid
Healthy U Behavioral

Prepaid Mental Health Plan (PMHP)

Base Contract

Effective: July 1, 2026 (SFY 2027)

Full Contract Term: July 1, 2026 – June 30, 2031

Attachment A - Utah Department of Health General Provisions

Attachment B – Scope of Work

Attachment C – Covered Services

Attachment D – Quality and Performance

Attachment E – Payment Methodology

Department of Health & Human Services

CONTRACT

251693535
DHHS Log Number

262703535
State Contract Number

1. CONTRACT NAME: The name of this contract is Prepaid Mental Health Plan Healthy U Behavioral SFY 27-31.

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

PAYMENT ADDRESS
UNIVERSITY OF UTAH HEALTH PLANS
6056 FASHION SQUARE DR #3104
MURRAY , UT 84107

MAILING ADDRESS
UNIVERSITY OF UTAH HEALTH PLANS
6056 FASHION SQUARE DR #3104
MURRAY, UT 84107

Vendor ID: 47425DM
Commodity Codes: 95262 Mental Health Services

3. GENERAL PURPOSE OF CONTRACT: The general purpose of this managed care contract is to provide inpatient and outpatient mental health services, and outpatient substance use disorder services

4. CONTRACT PERIOD: The service period of this contract is 07/01/2026 through 06/30/2031, unless terminated or extended by agreement in accordance with the terms and conditions of this contract.

5. CONTRACT AMOUNT: DHHS agrees to pay $32,340,000.00 in accordance with the provisions of this contract.

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

CONTRACTOR CONTACT
Leigha Rodak
(801) 646-4836
leigha.rodak@hsc.utah.edu

DHHS CONTACT
Alfonsina Maya Jensen
801-776-7317
mayajensen@utah.gov

7. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:
Attachment A: Utah Department of Health and Human Services Public Entity Terms and Conditions

Attachment B: Scope of Work
Attachment C: Covered Services
Attachment D: Quality and Performance
Attachment E: Payment Methodology

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

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Contract with Utah Department of Health & Human Services and UNIVERSITY OF UTAH HEALTH PLANS**, Log #** 251693535

DHHS
Signature

By: _____ 07/25/2026
Tracy Gruber
Commissioner
Department of Health & Human Services
Date

CONTRACTOR:
Signature

Electronically Signed By

By: [redacted] 07/21/2026
Chad Westover
CEO
Date

RECEIVED AND PROCESSED BY DIVISION OF FINANCE

Attachment A: Utah Department of Health and Human Services Public Entity Terms and Conditions

1. **Definitions:**

"**Authorized Persons**" means the Contractor's employees, officers, partners, Subcontractors, or other agents of the Contractor who need to access State Data to enable the Contractor to perform its responsibilities under this contract.

"**Contract Signature Page(s)**" means the DHHS cover page(s), including the page(s) signed by the parties.

"**DHHS**" means the Utah Department of Health and Human Services.

"**Goods**" means all types of tangible personal property (commodities), including but not limited to materials, supplies, Work Product, and equipment that the Contractor is required to deliver to DHHS. To the extent this contract entails delivery or performance of services (including maintenance, installation, or product support) such services will be deemed "Goods" within the meaning of the Utah Uniform Commercial Code when reasonable to do so.

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

"**Services**" means the furnishing of labor, time, or effort by the Contractor pursuant to this contract. Services include those professional services identified in Section 63G-6a-103 of the Utah Procurement Code.

"**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.

"**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 State's hardware, the Contractor's hardware, or exists in any system owned, maintained or otherwise controlled by the State or by the Contractor. State Data includes any federal data that DHHS controls or maintains, that is protected under federal laws, statutes, and regulations. DHHS may identify, during and after this contract, additional reasonable types of categories of information that must be kept confidential under federal and State laws.

"**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 the Contractor's manufacturers, distributors, and suppliers.

"**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.

"**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, deliverable, 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 the Contractor or the Contractor's Subcontractors (either alone or with others) pursuant to this contract. Work Product will be considered a work made for hire under federal, State, and local laws; and all interest and title will be transferred to and owned by DHHS. Notwithstanding anything in the immediately preceding sentence to the contrary, Work Product does not include any DHHS intellectual property, the Contractor's intellectual property (that it owned or licensed prior to this contract) or third party intellectual property.

2. **Governing Law and Venue:** This contract is governed by the laws, rules, and regulations of Utah. Any action or proceeding arising from this contract must be brought in a court of competent jurisdiction in the State. Venue is in Salt Lake City, in the Third Judicial District Court for Salt Lake County.

3. **Amendments:** This contract may only be amended by mutual written agreement signed by both parties.

4. **No Automatic Renewals:** This contract will not automatically renew.

5. **Scope Changes:** Any changes to the scope of Goods or Services required under this contract must be executed by written amendment signed by the parties.

6. **Laws and Regulations:** The Contractor shall comply with all applicable federal, state, and local laws, rules, codes, orders, and regulations, including applicable licensure and certification requirements. If this contract is funded by federal funds, either in whole or in part, then any federal regulation related to the federal funding, including CFR Appendix II to Part 200, will take precedence over any conflict with this Attachment A.

7. **Independent Contractors:** The Contractor shall ensure that any Subcontractors act in an independent capacity and not as officers, employees, or agents of DHHS.

8. **Invoicing:** Unless otherwise stated in the scope of work, the Contractor shall submit invoices along with any supporting documentation within 20 days following the last day of the month in which the Services were provided or within 20 days of the delivery of the Goods to DHHS. The Contractor shall list this contract number on all invoices, freight tickets, and correspondence relating to this contract. The prices paid by DHHS will be those prices listed in this contract, unless the Contractor offers a prompt payment discount on its invoice. DHHS may adjust or return any invoice reflecting incorrect pricing. The Contractor shall submit all final billings under this contract within 14 days of expiration or termination of the contract, regardless of the Contractor's billing period. Notwithstanding the foregoing, the Contractor shall submit all billings for Services performed or Goods delivered on or before June 30th of a given fiscal year no later than July 14th of the following fiscal year, regardless of Contractor's billing period or the expiration or termination date of this contract. DHHS may reject any invoice or claim for payment or reimbursement if received by DHHS after the requirements stated in this contract, but in no case will DHHS pay for items billed later than twelve months after the fiscal year ending June 30th that the Contractor's services or goods were provided or expected under the contract, or for contracts with Medicaid, later than Medicaid deadlines.

9. **Payment**:

   9.1. DHHS shall pay the contracted amounts, less amounts collected by the Contractor from any other Person not a party to this contract legally liable for the payments for the Goods and Services.

   9.2. DHHS shall make payments within 30 days after a correct invoice is received.

   9.3. If funding to DHHS 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 DHHS, DHHS shall reimburse the Contractor for Goods delivered and Services performed through the date of cancellation or reduction, and DHHS will not be liable for any future commitments, penalties, or liquidated damages.

   9.4. Upon 30 days written notice, the Contractor shall reimburse DHHS for funds DHHS is required to reimburse a third party funding source resulting from the actions of the Contractor or its Subcontractors.

10. **Nonappropriation of Funds, Reduction of Funds, or Changes in Law:** Upon written notice delivered to the Contractor, DHHS may immediately terminate this contract in whole or in part, or proportionately reduce the Goods and Services due and the amounts due, if DHHS 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) a change in appropriations, available funds, or budgets affects DHHS'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, DHHS shall pay the Contractor for the Goods and Services properly ordered

until the effective date of said notice. DHHS will not be liable for any performance, commitments, penalties, or liquidated damages that accrue after the effective date of said written notice.

11. **Suspension of Work:** DHHS shall give the Contractor written notice should DHHS suspend the Contractor's responsibilities under this contract. The Contractor's responsibilities may be reinstated upon advance written notice from DHHS.

12. **Indemnification**:

    12.1. If the Contractor is a governmental entity, the parties 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 this contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.

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

13. **Intellectual Property Indemnification**: The Contractor shall indemnify and hold DHHS harmless from and against any and all damages, expenses (including reasonable legal fees), claims, judgments, liabilities, and costs in any action or claim brought against DHHS 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 the Contractor's liability, such limitations of liability will not apply to this section.

14. **Debarment:** DHHS may immediately terminate this contract if DHHS determines that the Contractor has been debarred, suspended, or otherwise lawfully excluded from participating in any agreement issued by a governmental entity, including but not limited to, being determined ineligible as a subcontractor of any governmental entity. The Contractor certifies that it is not currently suspended, debarred, or otherwise prohibited to enter this contract. The Contractor shall immediately notify DHHS if the Contractor becomes suspended, debarred, or otherwise ineligible for this or any other agreement issued by a governmental entity.

15. **Termination and Default**:

    15.1. **Termination for Convenience.** DHHS may terminate this contract without cause, upon 30 days written notice to the Contractor. If the Contractor terminates this contract without cause, DHHS may treat the Contractor's action as a default under this contract.

    15.2. **Termination for Cause.** Each party may terminate this contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall give written notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within 10 days of the notice. If the default is not cured within the 10 days, the party giving notice may terminate this contract 40 days from the date of the initial notice of default or at a later date. Time allowed for cure will not diminish or eliminate the Contractor's liability for damages.

    15.3. **Payment After Termination.** DHHS shall pay the Contractor for the Goods delivered and Services properly performed under this contract up to the effective date of the notice of termination. The Contractor agrees that in the event of termination, the Contractor's sole remedy and monetary recovery from DHHS or the State is limited to full payment for all Goods delivered and Services properly performed as authorized under this contract up to the date of termination, as well as any reasonable monies owed as a result of the Contractor having to terminate other contracts necessarily and appropriately entered into by the Contractor pursuant to this contract. In the event of such termination, the Contractor shall promptly deliver to the State all Work Product, which includes but is not limited to all manuals, forms, contracts, schedules, reports, and any and all documents produced by the Contractor under this contract up to the date of termination.

15.4. **Cover.** If DHHS terminates this contract for cause, DHHS may procure replacement Goods or Services upon terms and conditions necessary to replace the Contractor's obligations. If the termination is due to the Contractor's failure to perform, and DHHS procures replacement Goods or Services, the Contractor agrees to pay any excess costs associated with obtaining the replacement Goods or Services.

15.5. **Default.** Any of the following events will constitute cause for DHHS to declare the Contractor in default of this contract: (i) the Contractor's non-performance of its requirements and obligations under this contract; or (ii) the Contractor's material breach of any term or condition of this contract. If the Contractor defaults in any manner in the performance of any obligation under this contract, or if audit exceptions are identified, DHHS may 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 the Contractor's failure to comply with federal regulations or State rules. In addition, DHHS may withhold amounts due the Contractor under this contract, any other current contract between DHHS and the Contractor, or any future payments due the Contractor to recover the funds. DHHS shall notify the Contractor of DHHS's action in adjusting the amount of payment or withholding payment. This contract is executory until such repayment is made.

16. Remedies: In addition to terminating this contract upon default or breach of the Contractor, DHHS may do one or more of the following: (i) exercise any remedy provided by law or equity; (ii) impose liquidated damages; (iii) debar or suspend the Contractor from receiving future contracts from DHHS or the State; and (iv) demand a full refund of any payment DHHS has made to the Contractor for Goods or Services that do not conform to this contract.

17. Reviews: DHHS may perform plan checks or reviews and require changes when needed. Such reviews do not waive the requirement of the Contractor to meet all of the terms and conditions of this contract.

18. Performance Evaluation: DHHS may conduct a performance evaluation of the Contractor's Services, including the Contractor's Subcontractors. DHHS may make the results of any evaluation available to the Contractor.

19. Public Information: The Contractor agrees that this contract is a public document and may be posted on the DHHS website. Related purchase orders, pricing documents, and invoices will also be public documents and may be available for public and private distribution in accordance with the State's Government Records Access and Management Act ("**GRAMA**"). DHHS and the State are not obligated to inform the Contractor of any GRAMA requests.

20. Publicity: The Contractor shall not advertise or publicize matters relating to this contract, or publicly use DHHS's name, without the prior written approval of DHHS. The Contractor shall impose this restriction on any subcontractors, and shall require subcontractors to impose this restriction on each lower tier of subcontractors.

21. Information Ownership: Except for confidential medical records held by direct care providers, if the Contractor uses any Subcontractors for activities arising out of this contract, the Contractor shall ensure it maintains exclusive ownership and title to all information gathered, reports developed, and conclusions reached in performance of this contract. The Contractor shall require any Subcontractors to obtain prior written consent from the Contractor prior to using or disclosing information gathered, reports developed, or conclusions reached in performance of activities arising out of this contract.

22. Information Practices: The Contractor shall establish, maintain, and practice information procedures and controls that comply with federal and state law including, as applicable, Utah Code Title 26B 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"). DHHS may require the Contractor to enter into a business associate agreement if applicable. The Contractor shall receive or request from DHHS only information about an individual that is necessary to the Contractor's performance of its duties and functions. The Contractor shall use the information only for purposes of this contract.

23. Secure Protection and Handling of State Data:

23.1. If the Contractor is given access to or stores State Data as part of this contract, the protection of State Data must be an integral part of the business activities of the Contractor to ensure that there is no inappropriate or unauthorized use of State Data. The Contractor shall safeguard the confidentiality, integrity, and availability of the State Data. The 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 this contract. The improper use or disclosure of confidential information is strictly prohibited.

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

23.3. The Contractor shall: (i) 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 this contract relates, and only for that purpose; (ii) advise its Authorized Persons of the proprietary nature of the State Data and of the obligations set forth in this contract and require Authorized Persons to keep the State Data confidential; (iii) 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 (iv) not disclose any State Data received by it to any third parties, except as permitted by this contract or otherwise agreed to in writing by DHHS.

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

24. Artificial Intelligence: The Contractor shall not use State Data in any generative artificial intelligence ("**GAI**") queries, training, or program creation without prior written permission from DHHS. The Contractor attests that its GAI models use only properly licensed material. The Contractor shall fully indemnify and hold DHHS harmless from all claims, loss, or damages related to the Contractor's use of GAI. Should the Contractor learn that State Data has been used in GAI queries without DHHS permission, the Contractor shall immediately notify DHHS. The Contractor shall inform DHHS of any GAI in the Goods or Services being contracted for prior to providing those Goods or Services to DHHS. The Contractor shall include annotations sufficient to comply with DTS Policy 4000-0008 (Generative AI Policy) when utilizing GAI in the creation of Goods and Services with the potential to impact DHHS intellectual property rights.

25. Intellectual Property Ownership: DHHS and the Contractor recognize that each has no right, title, or interest, proprietary or otherwise in the intellectual property owned or licensed by the other, unless agreed upon by the parties in writing. All deliverables, documents, records, programs, data, articles, memoranda, and other materials not developed or licensed by the Contractor prior to the execution of this contract, but specifically created or manufactured under this contract, is considered work made for hire, and the Contractor shall transfer any ownership claim to DHHS.

26. Work Product Ownership: In the event that the Contractor provides Work Product to DHHS pursuant to this contract, the Contractor grants the ownership in Work Product, which has been developed and delivered by the Contractor exclusively for DHHS and is specifically within the framework of fulfilling the Contractor's obligations

under this contract. Work Product will be deemed work made for hire, such that all intellectual property rights, title, and interest in the Work Product will pass to DHHS, to the extent that the Work Product is not recognized as work made for hire, the Contractor hereby assigns to DHHS any and all copyrights in and to the Work Product, subject to the following:

26.1. The Contractor has received payment for the Work Product,

26.2. 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

26.3. The 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 the Contractor in the course of performing the Services or creating the Work Product, other than portions that specifically incorporate proprietary or confidential information or Work Product of DHHS (collectively, the "**Residual IP**"), even if embedded in the Work Product.

26.4. The Contractor shall not distribute or market Work Product, not including the Contractor's Intellectual Property Rights, Background IP, and Residual IP, without written approval by DHHS.

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

27. Software Ownership: If the Contractor develops or pays to have developed computer software exclusively with funds or proceeds from this contract to perform its obligations under this contract, or to perform computerized tasks that it was not previously performing to meet its obligations under this contract, the computer software will be exclusively owned by or licensed to DHHS. If the 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 this contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under this contract, the addition will be exclusively owned by or licensed to DHHS. In the case of software owned by DHHS, DHHS grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this contract. In the case of software licensed to DHHS, DHHS grants to the Contractor permission to use the software in the performance of this contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this contract. If the Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by this contract, then to the extent allowed by the license agreement between the Contractor and the owner of the software, the Contractor grants to DHHS a continuing, nonexclusive license for either DHHS or a different contractor to use the software in order to perform work substantially identical to the work performed

by the Contractor under this contract. If the Contractor cannot grant the license as required by this section, then the Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under this contract in such a manner to allow DHHS or another contractor to continue the work performed by the Contractor under this contract.

28. **Updates and Upgrades**: The Contractor grants to DHHS a non-exclusive, non-transferable license to use upgrades and updates provided by the Contractor. Such upgrades and updates are subject to the terms of this contract. DHHS shall download, distribute, and install all updates as released by the Contractor. The Contractor shall use commercially reasonable efforts to provide DHHS with work-around solutions or patches to reported software problems that may affect DHHS's use of the software during the length of this contract.

29. **Technical Support and Maintenance**: If technical support and maintenance is a part of the Goods or Services that the Contractor provides under this contract, the Contractor will use commercially reasonable efforts to respond to DHHS in a reasonable time when DHHS makes technical support or maintenance requests regarding the Goods or Services.

30. **Equipment Purchase**: The Contractor shall obtain prior written DHHS approval before purchasing any equipment, as defined in the Uniform Guidance, with contract funds.

31. **Acceptance and Rejection:** DHHS will have 30 days after the performance of the Services or delivery of the Goods to perform an inspection of the Goods or Services to determine whether the Goods and Services conform to the standards specified in this contract prior to acceptance of the Goods or Services by DHHS. If the Contractor delivers nonconforming Goods or Services, DHHS may, at its option and at the Contractor's expense: (i) return the Goods or Services for a full refund; (ii) require the Contractor to promptly correct or re-perform the nonconforming Goods or Services subject to the terms of this contract; or (iii) obtain replacement Goods or Services from another source, subject to the Contractor being responsible for any cover costs.

32. **Record Keeping, Audits, and Inspections**:

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

    32.2. The Contractor shall retain all records which relate to disputes, litigation, and claim settlements arising from contract performance or cost or expense exceptions, until all disputes, litigation, claims, or exceptions are resolved.

    32.3. The 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 scope of work, the Contractor shall 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 Legal Compliance Audit Guide. The Contractor shall send copies of required reports to dhhsfinancialreports@utah.gov.

    32.4. If the Contractor enters into an agreement with a subrecipient, the Contractor shall report all Federal Funding Accountability and Transparency Act (FFATA) requirements to DHHS each time funding is awarded or amended.

33. **Standard of Care:** The Services of the Contractor and its Subcontractors must 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. The Contractor shall be liable to DHHS and the State for claims, liabilities, additional burdens, penalties, damages, or third party claims, to the extent caused by wrongful acts, errors, or omissions that do not meet this standard of care.

34. **Employment Practices:** The Contractor shall abide by the following employment laws, as applicable and as amended: Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e et seq.) 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; 45 C.F.R. § 90 and 29 C.F.R. Part 1625 which prohibits discrimination on the basis of age; Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, which prohibits discrimination on the basis of disabilities; Utah Executive Order No. 2006-0012, dated December 13, 2006, which prohibits unlawful harassment in the workplace; Utah Code § 26B-7-503, Utah Indoor Clean Air Act which prohibits smoking in enclosed public places; 41 C.F.R. Part 60, which prohibits discrimination on the basis of sex, and Executive Order 11375, which implements those regulations for federal contractors; 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; 40 U.S.C. § 3701 et seq., 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; Utah Code § 34A-5, the Utah Antidiscrimination Act; and Utah Code § 34A-11, the Genetic Testing Restrictions on Employment Act. The Contractor further agrees to abide by any other laws, regulations, or orders that prohibit the discrimination of any kind of any of the Contractor's employees or Persons served.

35. **Federal Requirements:** The Contractor shall abide by the following federal statutes, regulations, and requirements, as applicable and as amended: 2 C.F.R. § 200.327 (Contract Provisions); 2 C.F.R. § 200.322 (Domestic preferences for procurements); 2 C.F.R. § 200.323(Recovered Materials) and 42 U.S.C. § 6962 (Section 6002 of the Solid Waste Disposal Act); 31 U.S.C. § 1352 (Byrd Anti-Lobbying); 45 C.F.R. Part 75 (HHS Awards); P.L. 109-282 as amended (FFATA); 31 U.S.C. § 3729 et seq. and Chapter 38 (False Claims Act); P.L. 109-171 (Deficit Reduction Act of 2005); 42 U.S.C. § 289 et seq. (Institutional Review Boards); 45 C.F.R. Part 46 (Human Subjects); 21 C.F.R. Parts 50 & 56 (FDA Human Subjects/IRB); 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2 (Substance Use Confidentiality, including the 2024 Final Rule updates); 42 U.S.C. § 241(d) and 42 C.F.R. Part 2a (Certificates of Confidentiality); 42 C.F.R. Part 50, Subparts B & C (Sterilizations/Abortions); 42 C.F.R. Part 93 (Research Misconduct, updated 2026); and the current NIH Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules; 42 U.S.C. § 2000d et seq. & 45 C.F.R. Part 80 (Title VI); 20 U.S.C. § 1681 et seq. & 45 C.F.R. Part 86 (Title IX); 42 U.S.C. § 6101 et seq. & 45 C.F.R. Part 91 (Age Discrimination); 42 U.S.C. § 12101 et seq. & 28 C.F.R. Parts 35 & 39 (ADA); 29 U.S.C. § 794 & 45 C.F.R. Part 84 (Section 504/Nondiscrimination, including 2024 updates); 42 U.S.C. § 10801 et seq. (Mental Illness Advocacy); 29 U.S.C. § 201 et seq. (FLSA); 29 U.S.C. § 206(d) (Equal Pay Act); 18 U.S.C. § 874 & 29 C.F.R. Part 3 (Copeland Anti-Kickback); 40 U.S.C. § 3142 & 29 C.F.R. Part 5 (Davis-Bacon); 40 U.S.C. § 3701 et seq. & 29 C.F.R. Part 5 (Contract Work Hours); 41 U.S.C. § 8101 et seq. (Drug-Free Workplace); 8 U.S.C. § 1324a (Employment Verification); 5 U.S.C. § 1501 et seq. (Hatch Act); 42 U.S.C. § 4321 et seq. & 40 C.F.R. Part 1500 et seq. (NEPA); 42 U.S.C. § 7401 et seq. (Clean Air Act); 33 U.S.C. § 1251 et seq. (Clean Water Act); 42 U.S.C. § 6322 (Energy Policy); 42 U.S.C. § 4106 (Flood Disaster Protection); 42 U.S.C. § 7181 et seq. (Pro-Children Act of 2001); 42 U.S.C. § 4728 et seq. (Merit System Standards); 37 C.F.R. § 401 et seq. (Rights to Inventions/Bayh-Dole Act); and 7 U.S.C. § 2131 et seq. (Animal Welfare). The Contractor shall include in any subcontracts termination clauses for cause and convenience, along with administrative, contractual, or legal remedies for instances where subcontractors violate or breach agreement terms and provide for such sanctions and penalties as may be appropriate.

36. **Incorporation of Legal Changes:** References to any statute, executive order, rule, or regulation in this agreement include amendments, modifications, extensions, recodifications, and successor provisions to such authority that are enacted after execution of this agreement; provided, however, that the Contractor will not be required to comply with any such statute, executive order, rule, or regulation as of the date it is repealed or otherwise terminated in its entirety without a successor provision.

37. **Waiver**: A waiver of any right, power, or privilege will not be construed as a waiver of any subsequent right, power, or privilege.

38. **Subcontracts:** The Contractor retains ultimate responsibility for performance of all terms, conditions, and provisions of this contract that are subcontracted or performed by a Subcontractor. When subcontracting, the Contractor agrees to use written subcontracts that conform to federal and State laws. If any Subcontractor is a subrecipient, the Contractor shall comply with all federal regulations governing subrecipients as set out in 2 C.F.R. Part 200. If the Contractor enters into an agreement with a subrecipient, the Contractor shall notify DHHS of its compliance with 2 C.F.R. Part 200 in the manner required by DHHS. If this contract utilizes funds from a federal

award, the Contractor shall apply 2 C.F.R. § 200.321 to any subcontracts, and the Contractor shall not subcontract to any party listed on the governmentwide exclusions in the System for Award Management ("**SAM**").

39. **Force Majeure**: Neither party will be held responsible for delay or default caused by fire, riot, acts of God, or war which is beyond the party's reasonable control. DHHS may terminate this contract after determining that the delay or default will likely prevent successful performance of this contract.

40. **Severability**: The invalidity or unenforceability of any provision, term, or condition of this contract will not affect the validity or enforceability of any other provision, term, or condition of this contract, which will remain in full force and effect.

41. **Survival of Terms:** Termination or expiration of this contract will not extinguish or prejudice DHHS's right to enforce this contract with respect to any default or defect in the Services that has not been cured.

42. **Notice**: Notice must be in writing and sent to dhhscontracts@utah.gov.

43. **Order of Precedence**: The terms of this contract will be reasonably interpreted and construed to avoid any conflict among the provisions. If there is any conflict between this contract's terms, the order of precedence (listed in order of descending precedence) among the terms is: (1) Contract Signature Page(s); (2) this Attachment A; (3) DHHS scope of work; (4) Any other attachments.

44. **Time is of the Essence**: The Contractor shall complete Services or deliver Goods by any deadline stated in this contract. For all Goods and Services, time is of the essence. The Contractor shall be liable for all reasonable damages to DHHS and the State, and anyone to whom the State may be liable, as a result of the Contractor's failure to timely perform the Services required under this contract.

45. **Contractor Contact Information:** The Contractor shall ensure that DHHS has accurate contact information for the Contractor at all times throughout the duration of this contract and throughout the duration of the Contractor's record retention responsibilities. The Contractor shall immediately notify DHHS of any changes to contact information.

46. **Prohibited Discriminatory Practices:** The Contractor shall not use contract funds for any prohibited discriminatory practice as defined by Utah Code § 53H-1-504.

47. **Remediation:** DHHS may monitor the Contractor's performance under this contract and require remediation. The Contractor shall comply with any remediation plan required by DHHS. The Contractor's failure to comply with a DHHS remediation plan will be deemed a material breach of this agreement.

48. **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.

(Revised: 2/24/2026)

Attachment B - SCOPE OF WORK

Article 1
INTRODUCTORY PROVISIONS

1.1 **Location Restrictions.** 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. Additionally, 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 **Notice Requirements.** Any notices that are not otherwise specified in this contract, but are permitted or required under this contract, shall be in writing and shall be transmitted by:

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

(2) personal delivery;

(3) expedited delivery; or

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

1.3 **Addresses.** Such notices shall be addressed as follows:

DHHS (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

DHHS (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:

Healthy U Behavioral Health

6056 Fashion Square Drive, Suite 3104

Murray, UT 84107

1.4 **Change in Information.** 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.

1.5 **Service Area.** The Service Area is the specific geographic area within which the Medicaid Eligible Individual must reside to enroll with the Contractor. The Service Area for this contract is Summit County.

1.6 **Capacity.** The Contractor shall provide adequate assurances and supporting documentation that the Contractor has the capacity to serve the expected enrollment in the Service Area.

1.7 **Residency in Service Area.** DHHS has sole discretion to determine whether an Enrollee resides in a particular Service Area.

1.8 **Mandatory/Voluntary Enrollment Service Areas.** Medicaid Eligible Individuals with reported county code(s) in the Service Area are mandatorily enrolled with the Contractor.

Article 2
DEFINITIONS

2.1 **Definitions.** In this contract, the following definitions apply:

"**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.

"**ACO**" means Accountable Care Organization, a Utah MCO that contracts with DHHS 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**" means adults with or without dependent children who are below the 133% Federal Poverty Level after the 5% allowable deduction.

"**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 16.22 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.

"**Agent**" means any Subcontractor, entity or 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.

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

"**API**" means Application Programming Interface, a set of standards-based interfaces that allow third party applications to access and exchange electronic health information for Medicaid Members.

"**Appeal**" means a review by an MCE of an Adverse Benefit Determination.

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

"**Capitation**" means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Contractor for the performance of all the Contractor's duties and obligations in accordance with this contract.

"**Capitation Payment**" means the payment DHHS makes periodically to the Contractor on behalf of each Enrollee for the provision of Covered Services under this contract and based on the actuarially sound Capitation Rate. DHHS 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 DHHS for each Medicaid eligibility group or Capitation Rate cell.

"**CHIP**" means the Children's Health Insurance Program authorized by Title XXI 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.

"**CMS**" means Centers for Medicare and Medicaid Services, 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.

"**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 DHHS 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.

"**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 DHHS's coverage and reimbursement code database located on DHHS's official website. The Coverage and Reimbursement Lookup Tool is a component of DHHS's Medicaid policy.

"**Covered Child**" means, in accordance with Utah Code Ann. § 31A-22-665, an Enrollee who, while in the custody of DCFS, was receiving Mental Health Treatment or Services from a Covered Mental Health Therapist and is no longer in the custody of DCFS. A Covered Child also includes a Covered Child's parent or guardian when acting on behalf of the Covered Child. A Covered Child does not include an Enrollee who, while in the custody of DCFS, was receiving Mental Health Treatment or Services from a residential treatment program, as that term is defined in Utah Code Ann. § 26B-2-101, a day treatment program or partial hospitalization program, or any other facility that provides a level of care higher than traditional outpatient services where Mental Health Treatment or Services are integrated into the facility's specialized program of care.

"**Covered Mental Health Therapist**" means a mental health therapist, as that term is defined in Utah Code Ann. § 58-60-102, who provides Mental Health Treatment or Services to a Covered Child while the Covered Child is in the custody of DCFS.

"**Covered Services**" means services and supplies identified in Article 1 of Attachment C of this contract that the Contractor is required to provide and pay for in accordance with the terms of this contract.

"**Crossover Claim**" means a Claim for an Enrollee who is also a Medicare beneficiary where Medicare pays a portion of the claim and Medicaid is billed for any remaining deductible and/or coinsurance or copayment amounts.

"**CVO**" means a Credentials Verification Organization that helps healthcare organizations verify the qualifications of their medical providers with credentialing, payer/provider enrollment, licensure application and sanctions monitoring, background screening, and policy and procedure consulting.

"**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.

"**DCFS**" means the Division of Child and Family Services in DHHS.

"**DHHS**" means the Department of Health and Human Services.

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

"**DOPL**" means Division of Professional Licensing, 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.

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

"**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.

"**Employee**" means any officer or staff of the Contractor.

"**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 items or services by an Enrollee that is subject to the requirements of 42 CFR §§ 438.242 and 438.818.

"**Enrollee**" means any Medicaid Eligible Individual whose name appears on DHHS's Eligibility Transmission as enrolled with the Contractor.

"**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.

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

"**EQR**" means External Quality Review, 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.

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

"**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.

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

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

"**FFP**" means Federal Financial Participation, which in accordance with 42 CFR § 400.203, is 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.

"**FFS**" means Fee-for-Service, 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 DHHS or Contractor.

"**FQHC**" means Federally Qualified Health Center, 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 physical health, oral health, mental health, and substance use disorder services. FQHCs provide services to persons of all ages, regardless of their ability to pay or their health insurance status.

"**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.

"**HAC**" means Hospital-Acquired Condition, 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.

"**HEDIS**" means Healthcare Effectiveness Data and Information Set, 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.

"**HHS**" means the federal Department of Health and Human Services, 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.

"**HIO**" means Health Insuring Organization, 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:

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

  (B) 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).

"**HOME program**" means the Healthy Outcomes Medical Excellence program, the Medicaid MCE operated by the University of Utah that is under contract with DHHS in which Medicaid Members may voluntarily enroll if they have a developmental disability.

The HOME program is a coordinated care program for meeting the medical and mental health needs of 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.

"**IHCP**" means Indian Health Care Provider, 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 USC § 1603).

"**IMD**" means Institution for Mental Diseases, which is 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.

"**Indian**" means any individual defined at 25 USC §§ 1603(13), 1603(28) or 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.

"**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.

"**Initial Contact**" means an initial request to the Contractor by an Enrollee, or the Enrollee's authorized representative, or an agency, or Provider for Enrollees who are seeking Covered Services for the first time. Initial Contacts are those made during the Contractor's regular business hours excluding those made to crisis services after hours or on weekends, and includes Enrollees who are in the community, but not a hospital, at the

time the contact is made. Initial Contacts may be made by telephone or in person. Initial Contacts are only those contacts that include discussion of an actual appointment for the first Covered Service. Contacts to generally discuss mental health or substance use disorder services are not Initial Contacts.

"**K Children**" means Enrollees identified in the Eligibility Transmission as being in Rate Cell K.

"**Legacy Medicaid Population**" means the eligible membership groups of children 0-18, K Children, pregnant women, blind and disabled, aged, members eligible under the cancer program, and adults on Family Medicaid programs.

"**LEIE**" means List of Excluded Individuals/Entities, the 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.

"**Local Mental Health/Substance Abuse Authority**" means the county authority responsible to provide mental health and substance use disorder services either directly or by contract providers to residents of the authority's county or counties in accordance with Utah Code Ann. § 17-77, Part 3 and Part 2 respectively.

"**LTSS**" means Long-term Services and Supports, which are 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 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, DHHS's written quality strategy for assessing and improving the quality of health care and services furnished by an 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 PMHP's Medicaid product.

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

"**MCE**" means Managed Care Entity, which includes MCOs, PIHPs, PAHPs, PCCMs, and HIOs. The Contractor is a PIHP.

"**MCO**" means Managed Care Organization, 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:

    (A) 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

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

"**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.

"**Medically Necessary or Medical Necessity**" means medically necessary service as defined by Utah Administrative Code R414-1-2(18).

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

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

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

"**Mental Health Treatment or Services**" means, in accordance with Utah Code Ann. § 31A-22-665, the services a Covered Child was receiving while in the custody of DCFS that may be continued through a single case agreement with a Non-Network Provider after the Covered Child is no longer in the custody of DCFS.

"**MLR**" means Medical Loss Ratio, the calculation the Contractor is required to quantify and report to DHHS in accordance with 42 CFR § 438.8.

"**NCQA**" means National Committee for Quality Assurance, 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.

"**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 this 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.

"**Non-Urgent Service**" means the first Covered Service provided to an Enrollee when, based on the report of the Enrollee or the Enrollee's authorized representative during the Initial Contact, symptoms are determined to be generally less intrusive and less serious than those requiring an Urgent Service.

"**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.

"**NPDB**" means National Practitioner Data Bank, 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.

"**ORS**" means Office of Recovery Services, an office within DHHS.

"**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 DHHS 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.

"**PAHP**" means Prepaid Ambulatory Health Plan, an entity that provides medical services to Enrollees under contract with DHHS 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.

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

"**PCP**" means a primary care provider, a health care provider the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. PCPs are responsible for delivering primary care services, coordinating and managing overall health, and authorizing referrals for other necessary care.

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

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

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

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

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

(5) is an officer or director of the Contractor including the Contractor's Board of Directors' members, if applicable; or

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

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

"**PIP**" means Performance Improvement Project, 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.

"**PIHP**" means Prepaid Inpatient Health Plan, an entity that:

(1) provides medical services to Enrollees under contract with DHHS, 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.

"**PMHP**" means Prepaid Mental Health Plan, a managed care plan that contracts with DHHS to provide to its Enrollees inpatient and outpatient mental health services and outpatient substance use disorder services.

"**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 PMHP.

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

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

"**QAPIP**" means Quality and Performance Improvement Program, an ongoing comprehensive program established and implemented by the Contractor in accordance with 42 CFR § 438.330, for the services it furnishes to its Enrollees.

"**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 this contract.

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

"**Readily Accessible**" means electronic information and services 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.

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

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

"**Risk Corridor**" means a risk sharing mechanism in which DHHS and the Contractor may share in profits and losses under this contract outside of a predetermined threshold amount.

"**SAM**" means System for Award Management, 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.

"**Serious Mental Illness**" means a mental, behavioral or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Serious Mental Illness applies to individuals who are 18 years of age or older.

"**Service Area**" means the counties enumerated in Article 1.5 of this attachment.

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

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

"**SFY**" means State Fiscal Year, the 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 Fair Hearing**" means the process set forth in subpart E of part 431 of CFR Title 42.

"**State Directed Payment**" means a contract arrangement that directs the Contractor's expenditures under 42 CFR § 438.6(c).

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

"**State Health Care Program**" means:

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

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

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

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

"**State Match**" means the current percentage of the State's share of Medicaid expenditures as defined under 42 CFR § 433.10.

"**State Plan**" means the Utah State Plan for organization and operation of the Medicaid program as defined in accordance with Section 1902 of the Social Security Act (42 USC 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. This definition of Subcontractor applies to attachments B, C, D, and E of this contract unless otherwise specified.

"**Suspension or 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.

"**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.

"**Timely Manner**" means in accordance with Utah Code Ann. § 31A-22-663, and effective January 1, 2027:

(1) no more than 15 calendar days after the day on which an Enrollee first attempts to access behavioral health services; and

(2) no more than 24 hours after the date and time an Enrollee first seeks to access urgent, emergency, or crisis behavioral health services.

"**TPL**" means Third Party Liability, a Third Party's obligation to pay all or part of the expenditures for Covered Services furnished under this contract.

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

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

"**Urgent Service**" means the first Covered Service provided to an Enrollee when the report of the Enrollee or the Enrollee's authorized representative during the Initial Contact does not indicate dangerousness but the Enrollee's functioning is seriously impaired and symptoms are moderate to severe.

"**Waste**" means overutilization of resources or inappropriate payment.

Article 3
OUTCOMES

3.1 **Outcomes.** DHHS will be able to search and find accurate information from the Contractor's submitted reports, completed corrective action plans, QAPIP, Encounter Data, and MLR reports. This information allows DHHS to conduct continuous monitoring of the Contractor's performance which will help ensure that the Contractor is providing access to quality care.

3.2 **Outcomes Measurement.** DHHS shall measure the Contractor's outcomes as follows:

(1) timely submission of reports specified in Article 20.11 of this attachment;

(2) as defined in Article 3 of Attachment D, successful EQR compliance reviews and as needed, successful implementation of corrective action plans;

(3) as defined in Article 3 of Attachment D, successful EQR reviews of the Contractor's QAPIP and as needed, successful implementation of corrective action plans;

(4) successful submission of Encounter Data as defined in Article 20.13 of this attachment; and

(5) successful submission of MLR reporting as defined in Article 20.21 of this attachment.

Article 4
MARKETING

4.1 **Marketing Activities.** The Contractor, its Employees, Network Providers, Agents, or Subcontractors shall not:

(1) conduct direct or indirect Marketing of the PMHP; or

(2) market to or otherwise attempt to influence DHHS's health program representatives or local health department staff to encourage Enrollees or Potential Enrollees to enroll with the Contractor.

4.2 **Prohibited Marketing Activities.** The Contractor, its Employees, Network Providers, Agents, or Subcontractors shall not:

(1) directly or indirectly, engage in door-to-door, telephone, email, texting, or other Cold-Call Marketing activities;

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

(3) distribute 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.

4.3 **Marketing Policies and Procedures.** The Contractor shall maintain written policies and procedures related to Marketing that ensure compliance with the requirements described in Article 4 of this attachment.

4.4 **DHHS Approval of Marketing Materials.** All Marketing Materials must be reviewed and have the approval of DHHS prior to distribution. The Contractor understands and agrees that when submitting any Marketing Materials to DHHS for review, DHHS 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 established under 42 CFR § 431.12 may occur only after DHHS approves the Marketing Materials for use by the Contractor. DHHS's review includes determining whether the Marketing materials are accurate and do not mislead, confuse, or defraud Potential Enrollees or DHHS.

4.5 **Distribution of Marketing Materials.** Once the Contractor has DHHS's approval of its Marketing materials, the Contractor shall distribute Marketing Materials in the Contractor's entire Service Area.

Article 5
ENROLLMENT AND DISENROLLMENT

5.1 **Enrollment by DHHS.** DHHS shall determine which Medicaid Eligible Individuals are to be enrolled with the Contractor.

5.2 **Retroactive Enrollment.** Enrollees made eligible for a retroactive period prior to the current month are not eligible for Contractor enrollment during the retroactive period.

5.3 **Period of Enrollment.** An Enrollee shall be considered enrolled with the Contractor during the months in which the Contractor receives a Capitation Payment from DHHS.

5.4 **Continuous Enrollment.** The Contractor shall assume that an Enrollee continues to be enrolled until DHHS 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 DHHS.

5.5 **Prohibition Against Conditions on Enrollment.** The Contractor shall:

(1) 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;

(2) not pre-screen or select Potential Enrollees on the basis of pre-existing health problems;

(3) not discriminate against Enrollees or Potential Enrollees on the bases defined in Section 1557 of the Affordable Care Act and 42 CFR § 438.3(d)(4) and shall not use any policy or practice that has the effect of discriminating on these bases; and

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

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

5.7 **Eligibility Transmissions.** DHHS shall provide the Contractor an Eligibility Transmission, which is an electronic file that includes data on individuals DHHS certifies as being Medicaid-eligible and who have been enrolled in the Contractor's PMHP. 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.

5.8 **Eligibility Transmission Standard.** 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.

5.9 **Critical Fields.** 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.

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

5.11 **Daily Eligibility Transmissions.** In addition to the monthly Eligibility Transmissions, DHHS shall send daily Eligibility Transmissions to report changes to the Contractor.

5.12 **Eligibility Transmission, Specific Types of Enrollees.** For purposes of the Eligibility Transmission the following designations apply:

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

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

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

5.13 **Eligibility File, Contractor Responsibilities.** The Contractor shall:

(1) be responsible for ensuring that it is using the most recent Eligibility Transmission to determine eligibility and when processing Claims;

(2) follow the policies and procedures found in DHHS's 834 Benefit and Enrollment Companion Guide, the HIPAA X12 Benefit Enrollment and Maintenance (834) Implementation Guide, and any amendments to these documents; and

(3) comply with any additional instruction in writing from DHHS given, whenever possible, at least 30 calendar days advance notice of any changes.

Article 6
ENROLLEE INFORMATION

6.1 **All Written Materials.** The Contractor shall:

(1) write all Enrollee and Potential Enrollee informational, instructional, and educational materials, including Enrollee handbooks, in a manner and format that may be easily understood and that are Readily Accessible to Enrollees and Potential Enrollees, and as close to the sixth-grade reading level as possible;

(2) due to complexity of the topics, not be held to this reading level as long as the material is easily understood;

(3) 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; and

(4) 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.

6.2 **Electronic Submission Limitations.** The Enrollee information required under Article 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.

6.3 **Contractor Education Mechanisms.** The Contractor shall have mechanisms in place to help Enrollees and Potential Enrollees understand the requirements and benefits of their plan.

6.4 **Auxiliary Aids and Services.** 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.

6.5 **Interpretive Services.** 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.

6.6 **Enrollee Notification of Language and Accessibility Services.** 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:

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

6.7 **Advance Directives.** 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.

6.8 **DHHS-Developed Definitions for Use in Enrollee Communications.** The Contractor shall use DHHS-developed definitions 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.

6.9 **Model Enrollee Notices.** DHHS shall provide model Enrollee notices to the Contractor. The Contractor shall ensure all content in DHHS's model notices is addressed in the Contractor's notices.

6.10 **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.

6.11 **Written Materials Critical to Obtaining Services.** The Contractor shall:

(1) 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; and

(2) include taglines that:

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

(B) are in a conspicuously visible font size;

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

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

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

6.12 **Provision of Enrollee Handbooks.** The Contractor shall provide each Enrollee an Enrollee handbook within a reasonable time after receiving notice of the Enrollee's enrollment.

6.13 **Model Enrollee Handbook.** The Contractor shall use the model Enrollee handbook developed by DHHS. DHHS shall designate which areas in the model Enrollee handbook that the Contractor is allowed to customize.

6.14 **Required Enrollee Handbook Information.** 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 and shall include at a minimum:

(1) benefits provided by the Contractor;

(2) how and where to access any benefits provided by DHHS, including any cost sharing, 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, an explanation that the service is not covered by the Contractor and how Enrollees can obtain information from DHHS 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;

(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 from Non-Network Providers;

(17) timeframes for offering a first Covered Service for an emergent, Urgent Service and Non-Urgent Service specified in Article 16.22 of this attachment;

(18) Enrollee rights as outlined in Article 15.2 of this attachment;

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

(20) the Enrollee's right to:

(A) file Grievances and request Appeals; and

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

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

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

(23) the availability of assistance in requesting Appeals;

(24) 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;

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

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

(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 DHHS.

6.15 **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.

6.16 **Enrollee Handbook Review and Approval.** The Parties shall comply with the following requirements:

(1) when requested by DHHS, the Contractor shall submit its Enrollee handbook to DHHS for review and approval. The handbook shall be submitted to DHHS with all changes from the previous version of the handbook tracked; and

(2) DHHS shall notify the Contractor in writing of its approval or disapproval within 30 calendar days after receiving the Enrollee handbook unless DHHS and the Contractor agree to another timeframe. If DHHS does not respond within the

agreed upon timeframe, the Contractor may deem such materials approved by DHHS.

6.17 **Notification to DHHS of Intended Changes to Enrollee Handbook.** If the Contractor intends to make any change to its Enrollee handbook, including changes that would impact the information specified in Article 6.14 of this attachment, the Contractor shall notify DHHS in writing within 60 calendar days of the intended effective date of the change.

6.18 **DHHS Determination.** DHHS shall, within 10 business days of the notification, determine if the change is significant and inform the Contractor of its decision;

6.19 **Contractor Notice to Enrollees of Significant Change.** If DHHS determines the intended change is significant, 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.

6.20 **Enrollee Handbook Updates.** DHHS and the Contractor shall also mutually determine the timeframe for updating the Enrollee handbook to reflect the change.

6.21 **DHHS Identification of Significant Change.** If DHHS identifies a significant change that would impact the information specified in Article 6.14 of this attachment, DHHS shall notify the Contractor in writing within 60 calendar days of the intended effective date of the change.

6.22 **Network Provider Directory.** 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 searchable 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;

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

(9) whether the Network Provider offers Covered Services via telehealth.

6.23 **Additional Network Provider Directory Requirements.** Effective January 1, 2027, in accordance with Utah Code Ann. § 31A-22-664, the Contractor shall comply with all additional requirements for Network Provider directories; however, the Contractor shall continue to comply with federal timeframes for updating Network Provider directories found in Article 6.24 of this attachment.

6.24 **Updates to Network Provider Directory.** The Contractor shall:

(1) update the paper Network Provider directory at least:

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

(B) quarterly, if the Contractor has a mobile-enabled electronic directory;

(2) update the electronic Network Provider directory no later than 30 calendar days after the Contractor receives updated Network Provider information or makes a change in its network of Providers; and

(3) make the Network Provider directory Readily Accessible on the Contractor's website and as specified by the Secretary of HHS, in a machine-readable file and format.

6.25 **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.

Article 7

ENROLLEE BENEFITS

7.1 **Standards for Provisions of Covered Services.** The Contractor shall:

(1) provide Enrollees, directly or through arrangements with Providers, all Medically Necessary Covered Services described in the State's Prepaid Mental Health Plan Waiver as promptly and continuously as is consistent with generally accepted standards of medical practice;

(2) 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;

(3) ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;

(4) 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;

(5) be permitted to 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:

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

(B) 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;

(6) 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; and

(7) in accordance with 42 CFR § 438.210, administer Medically Necessary Covered Services in a manner that takes into account:

(A) 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;

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

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

7.2 **Scope of Services.** The Contractor:

(1) shall be, except as otherwise provided for cases of Emergency Services, responsible for arranging all Covered Services listed in the State's Prepaid Mental Health Plan Waiver, unless otherwise stated in this contract;

(2) shall be 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;

(3) may, in addition to services covered under the State Plan, or the State's Prepaid Mental Health Plan Waiver, 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;

(4) shall deliver Covered Services in compliance with the requirements of subpart K of 42 CFR § 438 insofar as applicable; and

(5) shall provide DHHS 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 DHHS within the timeframes requested by DHHS.

7.3 **Changes to Benefits.** Amendments, revisions, or additions to the State Plan, the Prepaid Mental Health Plan Waiver or to State or federal regulations, guidelines, or policies, insofar as they affect the scope or nature of benefits available to a Medicaid Member, shall be considered incorporated by this contract and the Contractor shall be required to provide those benefits to Enrollees. When possible, DHHS shall provide written notice to the Contractor of any amendments, revisions, or additions prior to implementation.

7.4 **Court and Administrative Orders Regarding Benefits.** The Contractor shall pay for Covered Services related to an Adverse Benefit Determination deemed eligible for payment in accordance with the terms of a court or administrative order.

7.5 **Covered Services - Emergency Services.** The Contractor shall:

(1) be responsible for coverage and payment of Emergency Services as described by this contract and by law;

(2) cover and pay Providers for Emergency Services, 24 hours a day 7 days a week;

(3) not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms;

(4) not refuse to cover Emergency Services based on the emergency room provider, hospital, or Fiscal Agent not notifying the Contractor of the Enrollee's screening and treatment within 10 calendar days of presentation for Emergency Services;

(5) 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; and

(6) pay Non-Network Providers for Emergency Services in accordance with Article 7.5 of this attachment.

7.6 **Emergency Services in an Outpatient Hospital.** Regarding Emergency Services delivered to Enrollees in an outpatient hospital, the Contractor shall be responsible for:

(1) paying only for those services rendered by a psychiatrist; and

(2) payment of these services regardless of whether the psychiatrist rendering the services is a Non-Network Provider.

7.7 **Payment Liability for Emergency Services.** The Contractor shall:

(1) not hold an Enrollee who has had an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition; and

(2) pay for both the screening examination and the services required to stabilize an Enrollee who has an Emergency Medical Condition. Services required to stabilize an Enrollee include 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.

7.8 **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.

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

7.10 **Disagreement Regarding Hospital Discharge or Transfer.** 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.

7.11 **Covered Services - Poststabilization Care Services.** The Contractor shall:

(1) be 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;

(2) 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 inpatient hospital psychiatric services after the Enrollee has received Emergency Services or other inpatient services;

(3) be 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; and

(4) be 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:

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

(B) the Contractor cannot be contacted; or

(C) 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.

7.12 **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 they had obtained the services through the Contractor. For purposes of cost sharing, Poststabilization Care Services begin upon inpatient admission.

Article 8

DELIVERY NETWORK

8.1 **Network Requirements.** The Contractor shall:

(1) 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;

(2) in establishing and maintaining the network of Network Providers, consider:

(A) the anticipated Medicaid enrollment;

(B) 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;

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

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

(E) 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;

(3) allow each Enrollee the ability to choose a Network Provider to the extent possible and appropriate; and

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

8.2 **Time and Distance Standards.** The Contractor shall:

(1) maintain provider network adequacy time and distance standards to ensure Enrollee access as described in Table 2 for adult and pediatric Covered Services;

(2) apply the standards in Table 2 according to each of its covered county's designation in Table 1; and

(3) apply the standards to adult mental health providers, adult substance use disorder providers, pediatric mental health providers, and pediatric substance use disorder providers.

8.3 **Variation in Time and Distance Standards.** The standards vary for urban, rural and frontier counties of the State. Table 1 includes the designation of each county as urban, rural, or frontier.

Table 1 - County Designation

Urban Counties	Rural Counties	Frontier Counties
Davis	Cache	Beaver
Salt Lake	Carbon	Box Elder
Utah	Iron	Daggett
Weber	Morgan	Duchesne
	Sanpete	Emery
	Sevier	Garfield
	Summit	Grand
	Wasatch	Juab
	Washington	Kane
		Millard
		Piute
		Rich
		San Juan
		Tooele
		Uintah
		Wayne

Table 2 - Network Adequacy Standards

Urban Counties	Rural Counties	Frontier Counties
90% of members must have access to Network Providers	80% of members must have access to Network Providers	75% of members must have access to Network Providers

within 10 driving miles or 15 minutes	within 35 driving miles or 45 minutes	within 60 driving miles or 70 minutes

8.4 **Time and Distance Standards - Exemption Process.** If the Contractor is unable to meet the network adequacy standards described in Table 2 above:

(1) the Contractor may request an exemption to these standards in writing and must include:

(A) the specific exception the Contractor is requesting;

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

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

(2) DHHS has sole discretion to allow for any exemption to the network adequacy standards.

8.5 **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.

8.6 **Out-of-Network Services.** 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:

(1) 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; and

(2) 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.

8.7 **Mental Health and Substance Use Disorder Services that Cannot Be Provided in a Timely Manner.** Effective January 1, 2027, in accordance with Utah Code Ann. § 31A-22-663, the Contractor shall:

(1) establish a procedure to assist Enrollees to access mental health and substance use disorder Covered Services from a Non-Network Provider when no Network Provider is available to provide the specified services in a Timely Manner (either in person or via telehealth);

(2) when the Contractor cannot meet the Timely Manner timeframes, enter into a single case agreement that allows the Enrollee to receive Covered Services from a Non-Network Provider, and include the following in the negotiated single case agreement:

(A) that the Contractor's reimbursement shall be at a rate negotiated by the Contractor and the Non-Network Provider;

(B) any terms that a Network Provider is subject to;

(C) the length of the single case agreement;

(D) that the Contractor's payment is payment in full; and

(E) that the Non-Network Provider may not seek additional payment from the Enrollee;

(3) ensure that the single case agreement only permits the Enrollee to receive services that are:

(A) within the Non-Network Provider's scope of practice; and

(B) mental health or substance use disorder services that are otherwise covered under this contract; and

(4) document all payments made to the Non-Network Provider under the single case agreement and provide the documentation to DHHS upon request.

8.8 **Timely Access.** The Contractor and its Network Providers shall meet DHHS standards for timely access to Covered Services, as described in Article 16.19 of this attachment, taking into account the urgency of the need for services. Additionally, the Contractor shall:

(1) 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; and

(2) make all Covered Services available 24 hours a day, 7 days a week, when Medically Necessary.

8.9 **Timely Access Monitoring.** The Contractor shall:

(1) 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 16.22 of this attachment;

(2) monitor its Network Providers regularly to determine compliance by Network Providers:

(3) if there is failure to comply, take corrective action against the Network Provider.

8.10 **Contractor Responsibility for Subcontractors.** 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.

8.11 **Contractor Delegation to Subcontractors.** If any of the Contractor's activities or obligations under this contract are delegated to a Subcontractor, the Contractor shall ensure that the contract or written agreement between the Contractor and the Subcontractor shall:

(1) specify the activities or obligations, and related reporting responsibilities of the Subcontractor;

(2) either provide for the revocation of the delegation of activities or obligations or specify other remedies in instances where DHHS or the Contractor determines that the Subcontractor has not performed satisfactorily; and

(3) require the Subcontractor to:

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

(B) agree that the DHHS, 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;

(C) make available, for the purposes of an audit, evaluation, or inspection by the DHHS, 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;

(D) agree that the right to audit by the DHHS, 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

(E) agree that if the DHHS, 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.

8.12 **Agreements with Providers and Subcontractors.** 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 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) that if the Contractor or Subcontractor makes an Adverse Benefit Determination to reduce, suspend or terminate services:

(A) that the Enrollee or the Enrollee's 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

(B) 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.

8.13 **Prohibitions on Enrollee Liability.** The Contractor's shall:

(1) ensure that its written agreements with its Providers and Subcontractors contain provisions stating that:

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

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

(i) DHHS does not pay the Contractor; or

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

(2) the Subcontractor or Provider 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.

8.14 **Additional Network Provider Requirements.** The Contractor shall ensure that:

(1) in accordance with Article 12 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;

(2) 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;

(3) its Network Providers are aware of the Contractor's QAPIP and activities through the inclusion of requirements securing cooperation with the Contractor's QAPIP and activities and allow the Contractor access to the medical records of Enrollees being treated by Network Providers via the Contractor's Network Provider agreements;

(4) all Network 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; and

(5) its Network Providers are enrolled with DHHS.

8.15 **Provider Enrollment with Medicaid.** The Contractor:

(1) shall only make payments to Providers who are enrolled with DHHS, except when the Provider is:

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

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

(C) a Network Provider, pending enrollment with DHHS, per 42 CFR § 438.602 (b)(2);

(2) may execute Network Provider agreements for up to 120 calendar days pending the outcome of DHHS's screening and enrollment process;

(3) shall terminate a Network Provider agreement immediately when:

(A) DHHS notifies the Contractor that the Network Provider cannot be enrolled;

(B) the Provider notifies the Contractor that they cannot be enrolled by DHHS;

(C) one 120-day period has expired without enrollment of the Provider by DHHS; or

(D) when DHHS notifies the Contractor that the enrollment of a Provider is terminated by DHHS; and

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

8.16 **Network Provider Selection.** The Contractor shall:

(1) have written policies and procedures for selection and retention of Network Providers that include the requirements found in this contract; and

(2) comply with any additional Network Provider selection requirements required by DHHS.

8.17 **Provider Discrimination Prohibited.** The Contractor's written Network Provider selection policies and procedures shall be consistent with 42 CFR §§ 438.214 and 438.12 and shall not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment or discriminate in the participation, reimbursement, or indemnification of 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:

(1) require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees;

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

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

8.18 **Notice to Non-Included Providers.** If the Contractor declines to include individuals or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason for its decision.

8.19 **DHHS Changes to Network Provider Selection Requirements.** DHHS shall provide the Contractor 60 calendar days advance written notice of any changes to DHHS's Network Provider selection requirements.

8.20 **Provider Credentialing and Recredentialing Policies and Procedures.** The Contractor shall:

(1) have written policies and procedures for credentialing potential Network Providers and recredentialing Network Providers in accordance with 42 CFR § 438.214(b)(2);

(2) have in its written policies and procedures that the Contractor follows DHHS's policies that require:

(A) Network Provider completion of Contractor written applications;

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

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

(D) procedures for viewing public records for any adverse actions, including the SAM and LEIE for sanctioning and/or federal debarment, Suspension, or Exclusion; and

(3) as applicable, use 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 8.20 of this attachment, the CVO searches satisfy this requirement:

(A) the Contractor may use the NPDB to satisfy the verifications required in Article 8.20 of this attachment as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on licensure and disciplinary status.

8.21 **Contractor Requirements 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.

8.22 **DOPL 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.

8.23 **Credentialing and Recredentialing Documentation.** The Contractor shall:

(1) maintain documentation of its credentialing and recredentialing activities; and

(2) upon request DHHS, 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.

8.24 **Reporting Non-Inclusion of Providers Due to Substantive Issues.** The Contractor shall:

(1) report to DHHS 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;

(2) electronically submit information relating to the non-inclusion of Providers to DHHS within 30 calendar days of the non-inclusion action using the DHHS-specified form; and

(3) 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.

8.25 **Federally Qualified Health Centers.** The Contractor shall not restrict an Enrollee's right to obtain FQHC services outside the PMHP through FFS.

8.26 **Network Provider Practice Guidelines.** The Contractor and its Network Providers shall adopt practice guidelines that are consistent with current standards of care. The 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.

8.27 **Dissemination of Network Provider Practice Guidelines.** The Contractor shall disseminate the practice guidelines to all affected Network Providers and, upon request, to Enrollees and Potential Enrollees.

8.28 **Contractor Utilization Management.** The Contractor shall:

(1) ensure that 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; and

(2) use the American Society of Addiction Medicine (ASAM) level of care placement criteria for management of substance use disorder services.

Article 9
PAYMENT OF PROVIDER CLAIMS

9.1 **General Requirements for Payment.** The Contractor shall:

(1) 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 447.46 unless the Contractor and the Network Provider have established an alternative payment schedule;

(2) 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;

(3) 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;

(4) recognize that the date of receipt is the date the Contractor receives the Claim as indicated by its date stamp on the Claim;

(5) recognize that the date of payment is the date of the check or other form of payment; and

(6) pay Claims submitted by the Provider when a Medicaid Member was enrolled in a different MCE or in FFS, and is retroactively enrolled, resulting in a retroactive Capitation Payment to the Contractor, and shall not require a Service Authorization Request or initially deny Claims due to timely filing.

9.2 **Special Rules for Payment for Provider Preventable Conditions.** The Contractor shall:

(1) ensure compliance with the requirements mandating Provider identification of Provider Preventable Conditions as a condition of payment;

(2) require that its Network Providers identify Provider Preventable Conditions in a form or frequency as specified by DHHS; and

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

9.3 **Payment Prohibitions under Federal Law.** In accordance with Section 1903(i)(2) of the Social Security Act, the Contractor:

(1) 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:

(A) under the Contractor's PMHP 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 in accordance with Sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act;

(B) 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 in accordance with 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

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

(2) shall, in accordance with Article 9.3(C)(1) of this attachment, suspend payments, send written notice to DHHS of the suspension of payments, and supply any information regarding the suspension and the allegation of Fraud as requested by DHHS.

9.4 **Additional Payment Prohibitions under Federal Law.** 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; and

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

9.5 **Federal Sanction and Exclusion Requirements.** In accordance with Section 1903(i)(2) of the Social Security Act, and 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:

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

(B) 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

(C) 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; and

(3) employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

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

(B) 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

(C) 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.

9.6 **Payment Exclusivity.** The Parties understand and agree that DHHS 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 DHHS in Title XIX of the Social Security Act, in 42 CFR, or when DHHS makes direct payments to Network Providers for graduate medical education costs approved under the State Plan.

9.7 **State Directed Payments - Huntsman Mental Health Institute (HMHI).** If DHHS receives authorization from CMS to make State Directed Payments to HMHI, the Contractor shall:

(1) pay HMHI a daily rate as determined by DHHS for inpatient psychiatric hospital services. The State Directed Payments will be implemented in accordance with the CMS approved Section 438.6(c) Preprint;

(2) only include payments for inpatient psychiatric hospital services;

(3) not include payments for professional services (i.e., 1500 claim form services) in this daily rate but shall make separate payments for professional services; and

(4) be subject to measures including corrective actions or liquidated damages in the event the Contractor does not implement the State Directed Payment as established by DHHS.

Article 10

PROGRAM INTEGRITY REQUIREMENTS

10.1 **Maintenance of Arrangements and Procedures to Guard Against Fraud, Waste, and Abuse.** In accordance with 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.

10.2 **Written Compliance Plan.** The Contractor or Subcontractor shall have a written compliance plan designed to identify and refer suspected Fraud, Waste, or Abuse activities. The Contractor's written compliance plan shall:

(1) designate the staff members and other resources being allocated to the prevention, detection, investigation and referral of suspected Provider Fraud, Waste, and Abuse; and

(2) include a description of the Contractor’s payment suspension process and how this process complies with Article 10.10 of this attachment.

10.3 **Contractor Cooperation and Coordination.** The Contractor shall cooperate and coordinate with DHHS, the Utah Office of Inspector General of Medicaid Services ("Utah OIG"), and MFCU in any Fraud, Waste, and Abuse activities and investigations.

10.4 **Contractor Submission of Written Compliance Plan to DHHS.** The Contractor shall submit the written compliance plan to DHHS by July 1st of each year which shall be subject to DHHS's approval. If DHHS does not provide a response to the Contractor within 90 calendar days of receiving the compliance plan, it will be deemed approved.

10.5 **Fraud, Waste, and Abuse Meetings.** The Contractor shall make reasonable efforts to attend and participate in quarterly Fraud, Waste, and Abuse meetings with DHHS, the Utah OIG and MFCU.

10.6 **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 designed to detect and prevent Fraud, Waste, and Abuse that include:

(1) written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under this 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 at the senior management level and is accountable to the Board of Directors 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 reporting to DHHS within 30 calendar days all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud;

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

(10) a provision for notification to DHHS when the Contractor 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;

(11) as detailed in Article 10.12 of this attachment, provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification processes on a regular basis;

(12) as detailed in Article 10.17 of this attachment, provisions for written policies for all Employees of the Contractor, and for any Subcontractor or Agent, that provide detailed information about the False Claims Act, other federal laws described in Section 1902(a)(68) of the Social Security Act, and applicable State laws, including information about the rights of employees of the Contractor, Subcontractor, or Agent to be protected as whistleblowers;

(13) as detailed in Article 10.7 of this attachment, provision for the prompt referral of any potential Fraud, Waste, or Abuse that the Contractor identifies to DHHS and the Utah OIG; and

(14) as detailed in Article 10.10 of this attachment, provision for the Contractor's suspension of payments to a Network Provider for which DHHS determines there is a credible allegation of Fraud, in accordance with 42 CFR § 455.23.

10.7 **Reporting Potential Contractor or Provider Fraud, Waste, or Abuse.** In accordance with Utah Code Ann. § 63A-13-101 et seq., if the Contractor or a Provider becomes aware of any potential Provider-related Fraud, Waste, or Abuse, the Contractor shall report to DHHS all incidents identified during the quarter using the DHHS-specified report.

10.8 **Credible Allegations.** When the Contractor has developed an investigation of potential Fraud, Waste or Abuse to the degree the allegation appears credible, the Contractor shall submit a written report of the allegation to the Utah OIG (mpi@utah.gov) and to DHHS (mc-fwa@utah.gov) within 15 business days of determining credibility. If there is risk of

imminent Enrollee harm, the Contractor shall submit the Fraud, Waste or Abuse written report as soon as possible but no later than 72 hours from determining credibility. A credible allegation of Fraud, Waste or Abuse means an indicia of reliability based on the allegations, facts, and evidence from the Contractor's review.

10.9 **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 DHHS.

10.10 **Obligation to Suspend Payments to Providers in Cases of Fraud.** The Contractor shall:

(1) have a provision to comply with 42 CFR § 438.608(a)(8); and

(2) first seek information from MFCU regarding possible ongoing investigations of the Provider if the Contractor intends to suspend payments to a Provider.

10.11 **DHHS Suspension of Payments.** If DHHS suspends payments to a Provider, and DHHS notifies the Contractor, the Contractor shall also suspend payments to that Provider until DHHS lifts the suspension.

10.12 **Contractor Service Verification - Written Policies and Procedures.** 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.

10.13 **Sampling Procedures.** 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:

(A) the Enrollee's name and Medicaid ID number;

(B) the date of each contact (if a prior attempt was unsuccessful);

(C) the method of contact;

(D) whether the Enrollee responded to the contact; and

(E) whether the Enrollee indicated they obtained the service; and

(3) the Contractor shall keep copies of correspondence.

10.14 **Other Methods.** If the Contractor uses methods other than the sampling procedures specified above to verify services billed by Providers were received by the Contractor's Enrollees, the method must include a minimum of 50 Enrollees who received a Covered Service during the SFY. The Contractor's written policies and procedures shall include a detailed description of the methods to be used. The Contractor may use a combination of the other method and the sampling method if needed to obtain a sample of a minimum of 50 Enrollees.

10.15 **Submission of Annual Service Verification Report.** The Contractor shall submit an annual SFY service verification report to DHHS using the DHHS-specified report.

10.16 **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.

10.17 **False Claims Act - Written Policies and Procedures.** 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 DHHS, the Contractor shall establish written policies and procedures for all Employees (including management), Subcontractors, and Agents that comply with the Act.

10.18 **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.

10.19 **Dissemination of False Claims Act Policies and Procedures.** The Contractor shall:

(1) to the extent the False Claims Act applies to the Contractor, have written procedures for disseminating its False Claims Act policies and procedures to its Employees, Subcontractors, and Agents;

(2) require that its Network Providers comply with the Contractor's False Claims Act policies and procedures; and

(3) 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.

10.20 **Prohibited Affiliations.** 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 five percent or more of the Contractor's equity who is:

(A) debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued under to Executive Order No. 12549 or under any guidelines implementing such order; or

(B) 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 in accordance with Executive Order No. 12549 or under any guidelines implementing such order;

(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 DHHS who is:

(A) debarred, suspended, or otherwise excluded from participating in procurement activities under FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order; or

(B) 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 under Executive Order No. 12549 or under guidelines implementing such order;

(3) in accordance with 42 CFR § 438.610(b), 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; or

(4) in accordance with 42 CFR § 455.101, a contract with Providers that DHHS has determined to be terminated from participation in any Federal Health Care Program.

10.21 **Screening for Prohibited Affiliations.** The Contractor shall:

(1) 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 DHHS, is required in this contract, the Contractor may use:

(A) 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 organizations that offer a CVO certification program; and

(ii) provides evidence of LEIE and SAM searches that include the dates of the searches; and

(B) the NPDB as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on Exclusions; and

(2) screen the following relationships to ensure the Contractor has not entered into a prohibited affiliation with:

(A) directors, officers, or partners of the Contractor;

(B) Subcontractors as governed by 42 CFR § 438.230;

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

(D) Network Providers; or

(E) 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.

10.22 **Requirements Before Entering into Relationships.** Before entering into a relationship with the individuals or entities listed in Article 10.21(2) of this attachment the Contractor shall, at minimum:

(1) conduct searches of the LEIE and SAM databases and any other database required by DHHS to ensure that the individuals listed in Article 10.21(2) of this attachment are not debarred, Suspended, or otherwise Excluded;

(2) maintain documentation showing that such searches were conducted; and

(3) for individuals or entities listed in Article 10.21(2) of this attachment not found in the database searches, 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 under Executive Order No. 12549 or under any guidelines implementing such order.

10.23 **Written Attestations.** To determine if the individuals or entities listed in Article 10.21(2) 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 under Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall:

(1) 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 under Executive Order No. 12549 or under any guidelines implementing such order; and

(2) include in the written attestation 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 in accordance with 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.

10.24 **Determination of Prohibited Affiliations.** 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.

10.25 **Other Entities.** If an entity other than the Contractor (for example, the Board of Directors) has the authority to enter into a relationship described in Article 10.21(2) of this attachment then the Contractor or the other entity shall conduct the required database searches and obtain the requisite written attestations.

10.26 **Monthly Searches.** If the Contractor determines, based on database search results or from the written attestation, that a prohibited affiliation would not result, the Contractor or the other entity shall conduct the monthly searches to ensure that any of those individuals or entities listed in Article 10.21(2) 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.

10.27 **Reporting Prohibited Affiliations.** The Contractor shall comply with the following reporting requirements:

(1) in the event that the Contractor determines that it is not in compliance and has entered into a prohibited affiliation with an individual or entity described in Article

10.21(2) of this attachment, the Contractor shall immediately, and no later than 30 calendar days, notify DHHS;

(2) notification to DHHS 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, the Contractor shall notify DHHS of the Exclusion by electronically submitting the information on DHHS's Disclosure of Excluded Provider form; and

(3) 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 in accordance with Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall provide an electronic copy of the written attestation to DHHS no later than 30 calendar days from the date the individual or entity provided the written attestation to the Contractor.

10.28 **DHHS Reporting Prohibited Affiliations.** To ensure compliance with 42 CFR § 1002.203, the DHHS, after having been notified of the Contractor's noncompliance:

(1) shall notify the Secretary of HHS of the noncompliance;

(2) may continue this existing contract with the Contractor unless the Secretary of HHS (in consultation with the HHS Inspector General) directs otherwise; and

(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 Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

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

10.30 **Provider Termination Requirement.** The Contractor must terminate any Providers from participating as a provider of services or persons in any network who have been terminated as described in section 1902(kk)(8) of the Social Security Act.

10.31 **Screening for Excluded Providers.** 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 DHHS 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:

(A) is certified by NCQA or other organization that offers a CVO certification program; and

(B) provides evidence of LEIE and SAM searches that include the dates of the searches; and

(2) the NPDB as long as the Contractor enrolls in NPBD's Continuous Query to ensure complete information on Exclusions.

10.32 **Database Search Requirements.** 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 DHHS to ensure that the providers are not Excluded Providers.

10.33 **Medicare-certified or Medicaid Provider Searches.** For providers that are Medicare-certified or are Medicaid providers, the Contractor needs 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.

10.34 **Contractor Delegation of Provider Searches and Monitoring.** The Contractor shall comply with the following requirements for delegation and monitoring:

(1) 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:

(A) searches of the Provider's director; and

(B) searches of the Provider's providers who deliver Covered Services incident to the Provider's obligations under its agreement with the Contractor;

(2) 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;

(3) 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;

(4) within 30 calendar days of either identifying an Excluded Provider or receiving Exclusion information from a Provider, the Contractor shall notify DHHS of the Exclusion by electronically submitting the information on DHHS's Disclosure of Excluded Provider Form; and

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

10.35 **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).

10.36 **OIG Notification of Excluded Providers.** When Utah OIG notifies DHHS of an Excluded Provider, provider sanction, or payment withhold, DHHS shall notify the Contractor by email within ten business days.

Article 11
DISCLOSURE OF OWNERSHIP OR CONTROL INFORMATION

11.1 **Disclosure Information.** The Contractor shall:

(1) in accordance with 42 CFR § 455.104, and using the DHHS-specified form, provide disclosures of each Person with an Ownership or Control Interest in the Contractor;

(2) include the following information in the disclosures for Persons with an Ownership or Control Interest:

(A) the person's name and address of any Person (individual or corporation) with an Ownership or Control Interest in the Contractor and the address for corporate entities must include as applicable primary business address, every business location and the P.O. Box address;

(B) date of birth and Social Security number (in the case of an individual);

(C) 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;

(D) 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;

(E) 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

(F) 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; and

(3) in accordance with 42 CFR § 455.104 and using the DHHS-specified form, provide disclosures of the Contractor's Managing Employees and include the following information:

(A) the person's name and address; and

(B) date of birth and Social Security number.

11.2 **Government-owned Entities.** 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.

11.3 **Non-Profit Entities.** If the Contractor is a non-profit entity:

(1) and organized as a corporation, the Contractor shall submit disclosures in accordance with Article 11.1 of this attachment; or

(2) 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.

11.4 **Officers/Directors - Corporations Only.** The Contractor shall comply with the following Ownership and Control Interest disclosure requirements:

(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 11.1(1) of this attachment;

(2) the term director also 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 11.1(1) of this attachment;

(5) the Contractor shall only disclose officers and directors of the Contractor. If the Contractor has indirect owners, the Contractor need not disclose the officers and directors of the indirect owners. 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 officers, directors or board members in accordance with Article 11.1(1) of this attachment; and

(6) if there are partners, the Contractor shall:

(A) disclose all general and limited partnership interests, regardless of the percentage; and

(B) only disclose partnership interest in the Contractor. The Contractor need not report partnership interests in the Contractor's indirect owners. 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 11.1(1) of this attachment.

11.5 **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 11.1(3) of this attachment.

11.6 **Reporting Timeframes.** The Contractor shall electronically submit the DHHS-specified MCE disclosure forms:

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

(2) upon the Contractor executing this contract with DHHS;

(3) upon renewal or extension of this contract;

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

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

11.7 **DHHS Review.** DHHS shall review the ownership and control disclosure submitted by the Contractor and any of its Subcontractors as required in 42 CFR § 438.608(c).

11.8 **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 information for a Person with an Ownership or Control Interest or as Managing Employee as required by Article 11 of this attachment.

Article 12

DISCLOSURE OF PHYSICIAN INCENTIVE PLANS

12.1 **Compliance with Federal Regulations.** The Contractor shall comply with the requirements set forth in 42 CFR §§ 422.208 and 422.210.

12.2 **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.

12.3 **Physician Incentive Plans, Contract Requirements.** In accordance with 42 CFR § 438.3(i), Physician Incentive Plan contracts between the Contractor and its physician or physician group Network Providers shall:

(1) have a defined performance period that can be tied to the applicable MLR reporting periods;

(2) be signed and dated by all appropriate parties before the commencement of the applicable performance period;

(3) include clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that the physician or physician group Network Provider must meet to receive the incentive payment; and

(4) specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including a date of payment.

12.4 **Contractor Reporting Requirements.** The Contractor shall:

(1) notify DHHS if the Contractor plans to operate a Physician Incentive Plan; and

(2) report to DHHS the following information for DHHS to determine whether the incentive plan complies with the regulatory requirements:

(A) 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;

(B) incentive plan contracts, and any documentation used to support the provider incentive payments;

(C) the type of incentive arrangement (e.g., withhold, bonus, Capitation arrangement, etc.);

(D) the percent of withhold or bonus, if applicable;

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

(F) 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.

12.5 **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.

12.6 **Information to Enrollees Relating to Physician Incentive Plans.** The Contractor shall provide the following information on its Physician Incentive Plan to any Enrollee upon request:

(1) whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;

(2) the type of incentive arrangement; and

(3) whether stop-loss protection is provided.

Article 13

AUTHORIZATION OF SERVICES AND NOTICES OF ADVERSE BENEFIT DETERMINATION

13.1 **Service Authorization and Notice of Adverse Benefit Determination.** 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 and shall:

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

(2) 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 behavioral health needs;

(3) 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;

(4) also notify the requesting Provider of the specific reason for the denial regardless of the method used to communicate that information; and

(5) 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.

13.2 **Timeframes and Procedures for Standard Service Authorizations.** When making standard Service Authorization approvals the Contractor shall provide notice to the Enrollee and Provider as expeditiously as the Enrollee's health condition requires, but no later than seven calendar days from the receipt of the Service Authorization Request, and:

(1) may extend the timeframe for making the decision by up to an additional 14 calendar days if:

(A) the Enrollee or the Provider requests an extension; and

(B) the Contractor justifies (to DHHS upon request) a need for additional information and how the extension is in the Enrollee's best interest; and

(2) if the Contractor extends the timeframe for making standard Service Authorization decisions:

(A) give the Enrollee written notice of the reason for the decision to extend the timeframe;

(B) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

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

13.3 **Adverse Benefit Determination - Denial of All or Part of a Service Authorization Request - Timeframes and Procedures.** 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:

(1) make the decision and follow the notification requirements found in Article 13.14 of this attachment and mail a Notice of Adverse Benefit Determination to the Enrollee as expeditiously as the Enrollee's health condition requires it, but no later than seven calendar days from receipt of the Service Authorization Request;

(2) be permitted to extend the timeframe by up to an additional 14 calendar days if:

(A) the Enrollee or the Provider requests an extension; and

(B) the Contractor justifies (to DHHS upon request) a need for additional information and how the extension is in the Enrollee's best interest; and

(3) if the Contractor extends the timeframe, the Contractor shall:

(A) give the Enrollee written notice of the reason for the decision to extend the timeframe;

(B) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

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

13.4 **Timeframes and Procedures for Expedited Service Authorization Decisions.** 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;

(2) may extend the 72-hour time period by up to 14 calendar days if:

(A) the Enrollee requests the extension; or

(B) the Contractor, upon request, justifies to DHHS a need for additional information and how the extension is in the Enrollee's interest; and

(3) shall follow the notification requirements found in Article 13.14 of this attachment and mail a Notice of Adverse Benefit Determination to the Enrollee, 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.

13.5 **Adverse Benefit Determination - 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 constitutes a denial of services and is considered an Adverse Benefit Determination. The Contractor shall follow notification requirements found in Article 13.14 of this attachment of this attachment and mail a Notice of Adverse Benefit Determination to the Enrollee and the Provider on the date that the timeframe expires.

13.6 **Adverse Benefit Determination - Reduce, Suspend or Terminate Previously Authorized Covered Services.** If the Contractor seeks to reduce, suspend, or terminate previously authorized Covered Services, this constitutes an Adverse Benefit Determination. The Contractor shall notify the requesting Provider and follow the notification requirements found in Article 13.14 of this attachment 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; or

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

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

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

(i) the Enrollee no longer wishes the services;

(ii) 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, which in this case, any discontinued services 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.

13.7 **Adverse Benefit Determination - Denial in Whole or in Part, Payment for a Service.** The Contractor shall:

(1) follow the notification requirements found in Article 13.14 of this attachment and 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; and

(2) follow the notification requirements found in Article 13.14 of this attachment and 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:

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

(B) 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.

13.8 **Exceptions to Required Notice of Adverse Benefit Determination.** 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; or

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

13.9 **Adverse Benefit Determination - Failure to Provide Covered Services in a Timely Manner.**

(1) Failure to meet the performance standards found in Article 16.22 of this attachment constitutes an Adverse Benefit Determination. The Contractor shall follow the notification requirements found in Article 13.14 of this attachment and mail a Notice of Adverse Benefit Determination to the Enrollee at the time that either the Contractor determines, or the Enrollee or the Network Provider informs the Contractor, that the applicable performance standard found in Article 16.19 of this attachment for offering the first service to the Enrollee cannot be met, and the Enrollee informs the Contractor or the Network Provider that they are not satisfied with this.;

(2) Effective January 1, 2027, in accordance with Utah Code Ann. § 31A-22-663, the Contractor shall provide a Notice of Adverse Benefit Determination to the Enrollee when the Contractor determines the applicable Timely Manner timeframe cannot be met, regardless of whether the Enrollee is satisfied with an appointment outside the Timely Manner timeframe, and shall follow the notification requirements found in Article 13.13 of this attachment of this attachment.

13.10 **Adverse Benefit Determination - Failure to Resolve Appeals and Grievances within Prescribed Timeframes.** 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 follow the notification requirements found in Article 13.14 of this attachment and 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. For

Appeals, the Contractor shall include in the Notice of Adverse Benefit Determination the procedures and timeframes for requesting a State Fair Hearing rather than information on requesting an Appeal and attach to the Notice of Adverse Benefit Determination a copy of the State Fair Hearing request form the Aggrieved Person can submit to request a State Fair Hearing.

13.11 **Adverse Benefit Determination - Failure to Resolve an Appeal within Timeframes.** 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 request for a State Fair Hearing as the Aggrieved Person has already exhausted the Contractor's Appeal process. The Contractor may not require the Aggrieved Person to go through the Contractor's Appeal process again.

13.12 **Adverse Benefit Determination - Denial of an Enrollee's Request to Dispute Financial Liability.** The Contractor shall follow the notification requirements in Article 13.14 of this attachment and mail 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.

13.13 **Provision of Notice of Adverse Benefit Determinations.** For any type of Adverse Benefit Determination, the Contractor shall provide the Notice of Adverse Benefit Determination to the Enrollee as well as to the Aggrieved Person if the Enrollee is not the Aggrieved Person.

13.14 **Required Content of Notice of Adverse Benefit Determination.** The Contractor's notice of Adverse Benefit Determination shall:

(1) be in writing and meet the language and format requirements outlined in Article 6.1 of this attachment; and

(2) explain the following:

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

(B) the reason for the Adverse Benefit Determination;

(C) 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 including Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

(D) the right to request an Appeal of the Adverse Benefit Determination with the Contractor;

(E) the procedures for requesting an Appeal;

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

(G) 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

(H) 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 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.

13.15 **Attachment to Notice of Adverse Benefit Determination – Written Appeal Request Form.** 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 or the Enrollee's representative to request continuation of services if the Adverse Benefit Determination is to reduce, suspend, or terminate previously authorized services; and include statements that:

(A) 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

(B) 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;

(4) include information on how the Appeal request form can be submitted promptly by email, fax, or other methods; and

(5) include an attached State's Fair Hearing request form, when the Contractor is required to inform Aggrieved Persons of their State Fair Hearing rights.

Article 14

GRIEVANCE AND APPEAL SYSTEM

14.1 **General Requirements.** The Contractor shall:

(1) have a Grievance and Appeal System for an Aggrieved Person that includes:

(A) a Grievance process whereby an Aggrieved Person may file a Grievance;

(B) an Appeal process whereby an Aggrieved Person may request an Appeal of an Adverse Benefit Determination; and

(C) procedures for an Aggrieved Person to access the State Fair Hearing system;

(2) incorporate all the Grievance and Appeal System requirements found in this contract into its written policies and procedures for Grievances and Appeals; and

(3) to the extent that any written notice is required by Article 14.1, Article 14.2, Article 14.3, Article 14.13, and Article 14.25 of this attachment, if the Enrollee is not the Aggrieved Person, provide a copy of notices to the Enrollee.

14.2 **Appeal Process Requirements.** 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:

(A) the Enrollee and the Enrollee's representative; or

(B) the legal representative of a deceased Enrollee's estate.

14.3 **Standard Appeals.** The Aggrieved Person may request a standard Appeal either orally or in writing.

14.4 **Timeframe for Requesting Standard Appeals.** 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.

14.5 **Standard Appeal Procedures.** The Contractor shall:

(1) 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;

(2) acknowledge, either orally or in writing, receipt of the standard Appeal request;

(3) provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments;

(4) inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the standard Appeal;

(5) 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;

(6) provide the above information free of charge and sufficiently in advance of the resolution timeframe;

(7) include as parties to the Appeal the Enrollee and the Enrollee's representative, or the legal representative of a deceased Enrollee's estate;

(8) ensure that the individuals who make the decision on a standard Appeal are individuals who:

(A) were not involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(B) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by DHHS, 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

(9) take into account all comments, documents, records, and other information submitted, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

14.6 **Timeframes for Standard Appeal Resolution and Notification.** The Contractor shall:

(1) complete each standard Appeal and provide a Notice of Appeal Resolution to the Aggrieved Person and the parties to the Appeal 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; and

(2) be permitted to extend the timeframe for completing the standard Appeal and providing a Notice of Appeal Resolution by up to 14 calendar days if:

(A) the Aggrieved Person requests the extension; or

(B) the Contractor shows, to the satisfaction of DHHS, upon its request, there is need for additional information and how the delay is in the Aggrieved Person's interest.

14.7 **Contractor Initiated Timeframe Extensions.** If the Contractor extends the timeframe for completing the standard Appeal and providing a Notice of Appeal Resolution, 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.

14.8 **Format and Content of Notice of Standard Appeal Resolution.** The Contractor shall provide a written Notice of Standard Appeal Resolution in accordance with format and language requirements found in Article 6.1 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:

(A) the right to request a State Fair Hearing and how to do so; and

(B) the right of the Enrollee or the Enrollee's representative to request continuation of disputed services during the State Fair Hearing if the standard Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services:

(i) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing;

(ii) 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

(iii) 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.

14.9 **Continuation of Disputed Services During Standard Appeals.** In accordance with 42 CFR §§§ 438.420, 438.404(b)(6) and 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 or the Enrollee's authorized representative, not including a Provider, submits a request for continuation of disputed services timely, which means filing on or before the later of the following:

(A) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or

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

14.10 **Duration of Continued Disputed Services.** 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, or the Enrollee or the Enrollee's representative withdraws the Appeal or State Fair Hearing request;

(2) the Aggrieved Person, or the Enrollee or the Enrollee's representative fails to request a State Fair Hearing within 10 calendar days after the Contractor sends the Notice of Appeal Resolution;

(3) the Enrollee or the Enrollee's authorized representative fails to submit to the State Fair Hearing office, within 10 calendar days after the Contractor sends the Notice of Appeal 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, or the Enrollee or the Enrollee's representative.

14.11 **Recovery of Disputed Service Costs.** If the final resolution of the standard 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 14.9 of this attachment and in accordance with 42 CFR § 431.230(b).

14.12 **Reversed Standard Appeal Decisions.** The Contractor shall:

(1) 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, 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; and

(2) 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, pay for those services in accordance with State policy and regulations.

14.13 **Expedited Appeals.** The Contractor shall establish and maintain an expedited Appeal process for 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 the 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 an Appeal could seriously jeopardize the Enrollee's life, physical and/or mental health, or ability to attain, maintain or regain maximum function.

14.14 **Authority to File.** The Aggrieved Person may request an expedited Appeal either orally or in writing.

14.15 **Timeframe for Requesting Expedited Appeals.** 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.

14.16 **Expedited Appeal Procedures.** The Contractor shall:

(1) ensure that punitive action is not taken against a Provider who either requests an expedited Appeal or supports an Aggrieved Person's Appeal request;

(2) give the Aggrieved Person any reasonable assistance in completing forms or taking other procedural steps related to an expedited Appeal request including auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability;

(3) acknowledge receipt of the expedited Appeal request either orally or in writing;

(4) provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments;

(5) inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the expedited Appeal;

(6) 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;

(7) provide the above information free of charge and sufficiently in advance of the resolution timeframe;

(8) include as parties to the Appeal the Enrollee and the Enrollee's representative, or the legal representative of a deceased Enrollee's estate;

(9) ensure that the individuals who make the decision on an expedited Appeal are individuals who:

(A) were not involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(B) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by DHHS, 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

(10) 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.

14.17 **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 Aggrieved Person and parties to the Appeal that the Aggrieved Person may file a Grievance regarding the denial of an expedited Appeal.

14.18 **Timeframes for Expedited Appeal Resolution and Notification.** The Contractor shall:

(1) complete each expedited Appeal and provide a Notice of Appeal Resolution to the Aggrieved Person and the parties to the Appeal as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the Contractor receives the expedited Appeal request; and

(2) be permitted to extend the timeframe for completing the expedited Appeal and providing notice by up to 14 calendar days if:

(A) the Aggrieved Person requests the extension; or

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

14.19 **Contractor Initiated Timeframe Extensions.** 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.

14.20 **Format and Content of Notice of Expedited Appeal Resolution.** The Contractor shall provide a written Notice of Expedited Appeal Resolution to the Aggrieved Person and the parties to the Appeal and make reasonable efforts to provide oral notice of the resolution of an expedited Appeal. The written Notice of Appeal Resolution shall be in accordance with format and language requirements found in 42 CFR § 438.10 and 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:

(A) the right to request a State Fair Hearing and how to do so; and

(B) the right of the Enrollee or the Enrollee's representative to request continuation of disputed services during the State Fair Hearing if the Expedited Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services and include:

(i) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing;

(ii) the timeframe for requesting a State Fair Hearing when continuation of services not requested, as well as when continuation of services is requested; and

(iii) 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) provide a copy of the Medicaid State Fair Hearing request form.

14.21 **Continuation of Disputed Services During Expedited Appeals.** In accordance with 42 CFR §§§ 438.420, 438.404(b)(6), and 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 or the Enrollee's authorized representative, not including a Provider, files a request for continuation of disputed services timely, which means filing on or before the later of the following:

(A) within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or

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

14.22 **Duration of Continued Disputed Services.** 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 or the Enrollee's authorized representative, not including a Provider, 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.

14.23 **Recovery of Disputed Service Costs.** If the final resolution of the expedited 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 14.21 of this attachment and in accordance with 42 CFR § 431.230(b).

14.24 **Reversed Expedited Appeal Decisions.** The Contractor shall:

(1) 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, 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 the Contractor receives notice reversing the determination, 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; and

(2) if the Contractor or the State Fair Hearing officer reverses a decision to deny authorization services while the expedited Appeal or State Fair Hearing was pending, pay for those services in accordance with State policy and regulations.

14.25 **State Fair Hearings.** The Contractor shall:

(1) when the Aggrieved Person has exhausted the Contractor's Appeal process and a final decision has been made, 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; and

(2) if the Appeal decision is adverse, provide notification to the Aggrieved Person that they may request a State Fair Hearing with DHHS and give to the Aggrieved Person the DHHS State Fair Hearing request form. The Contractor shall inform the Aggrieved Person that:

(A) 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

(B) 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.

14.26 **Parties to the State Fair Hearing.** 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.

14.27 **Examination of Information.** 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.

14.28 **Rights and Opportunities for the Parties.** 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.

14.29 **De Novo Hearing.** The State Fair Hearing with DHHS is a de novo hearing. If the Aggrieved Person requests a State Fair Hearing with DHHS, all parties to the hearing are bound by DHHS's decision until any judicial reviews are completed. Any decision made by DHHS pursuant to the hearing shall be subject to appeal rights as allowed by State and federal laws.

14.30 **State Fair Hearing Decision Notification.** 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.

14.31 **Final Administrative Action.** 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:

(A) 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

(B) where permitted, the date the Aggrieved Person filed for direct access to a State Fair Hearing; and

(2) as expeditiously as the Enrollee's health condition requires, but no later than three business days after DHHS receives from the Contractor the case file and

information for any appeal of denial of a service that, as indicated by the Contractor:

(A) 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

(B) was resolved within the timeframe for expedited resolution but reached a decision wholly or partially adverse to the Aggrieved Person.

14.32 **Recovery of Disputed Service Costs.** If the final resolution of the 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 State Fair Hearing was pending to the extent the services were furnished solely because of the requirements found in Article 14.21 of this attachment and in accordance with 42 CFR § 431.230(b).

14.33 **Grievances.** The Aggrieved Person, the Enrollee or the Enrollee's representative may file a Grievance with the Contractor.

14.34 **Timeframe for Filling a Grievance.** Grievances may be filed at any time orally or in writing.

14.35 **Grievance Procedures.** The Contractor shall:

(1) give Enrollees any reasonable assistance in completing required forms for submitting a written Grievance and taking other procedural steps related to the Grievance, including auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability;

(2) acknowledge receipt of the Grievance either orally or in writing;

(3) ensure that the individuals who make the decision on a Grievance are individuals who:

(A) were not involved in any previous level of review or decision-making involving the Grievance nor a subordinate of any such individual; and

(B) if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by DHHS, 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

(4) 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.

14.36 **Timeframes for Grievance Resolution and Notification.** The Contractor shall:

(1) 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; and

(2) be permitted to extend the timeframe for disposing of the Grievance and providing notice by up to 14 calendar days if:

(A) the Enrollee requests the extension; or

(B) the Contractor shows that there is need for additional information and that the delay is in the Enrollee's interest, upon DHHS request.

14.37 **Contractor Initiated Extension.** 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 they disagree with that decision.

14.38 **Notification of Grievance Disposition.** The Contractor shall notify the affected parties in writing of the disposition of a written Grievance. For Grievances received orally, the Contractor shall notify the affected parties of the disposition orally or in writing.

14.39 **Grievances Received by DHHS.** If the Aggrieved Person, the Enrollee or the Enrollee's representative files a Grievance with DHHS, DHHS shall:

(1) apprise the Enrollee or the Enrollee's representative of their right to file a Grievance with the Contractor and how to do so; and

(2) if the individual prefers, promptly notify the Contractor of the Grievance.

14.40 **Contractor Responsibilities for Grievances Referred by DHHS.** The Contractor shall:

(1) follow the procedures and timeframes outlined above for Grievances; and

(2) notify the affected parties and DHHS, in writing, of the disposition of the Grievance.

14.41 **Maintenance of Appeal and Grievance Records.** The Contractor shall maintain complete records of all Appeals and Grievances.

14.42 **Reporting Requirements.** The Contractor shall submit reports summarizing Appeals and Grievances using the DHHS-specified report.

14.43 **Document Maintenance, Appeals.** The Contractor shall accurately, and in a manner accessible to the DHHS 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:

(A) date of the oral requests;

(B) date of acknowledgement of oral requests for expedited Appeals and method of acknowledgment, orally or in writing;

(C) a general description of the Appeal request; and

(D) 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.

14.44 **Document Maintenance for Oral and Written Grievances.** The Contractor shall:

(1) using its previously established verbal complaint logging and tracking system, log all oral Grievances and include:

(A) the date the Grievance was received;

(B) a general description of the Grievance;

(C) the name of the Enrollee for whom the Grievance was filed;

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

(E) the name of the person taking the Grievance;

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

(G) the date of each review, or if applicable, review meeting;

(H) the resolution, and date of resolution at each level of review, or if applicable, review meeting;

(I) the name of the person resolving the Grievance;

(J) 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

(K) 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; and

(2) accurately, and in a manner accessible to DHHS and available upon request to CMS, maintain all written Grievances and copies of the written notices of resolution to the affected parties.

Article 15
ENROLLEE RIGHTS AND PROTECTIONS

15.1 **General Requirements.** The Contractor shall:

(1) develop and maintain written policies regarding Enrollee rights and protections;

(2) 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;

(3) ensure information on Enrollee rights and protections is provided to all Enrollees by including Enrollee rights and protections in its Enrollee handbook; and

(4) 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.

15.2 **Written Information on 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 in a manner and format that may be easily understood and is Readily Accessible by Enrollees and Potential Enrollees;

(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 164.526;

(7) the right to be furnished health care services in accordance with access and quality standards contained in this contract; 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 DHHS, the Contractor, or its Network Providers.

15.3 **Network Provider-Enrollee Communications.** 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.

15.4 **Objection to Services on Moral or Religious Grounds.** Subject to the information requirements in Article 15.4(1) and Article 15.4(2) of this attachment, if the Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service because of the requirements in Article 15.3 of this

attachment, the Contractor shall not be 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 DHHS about the services it does not cover prior to signing this contract or whenever it adopts the policy during the term of this 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.

15.5 **DHHS Notification for Obtaining Services Contractor Objects to on Moral or Religious Grounds.** DHHS shall notify Enrollees of how 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.

15.6 **Advance Directives.** The Contractor shall:

(1) maintain written policies and procedures on Advance Directives for all adults receiving medical care by or through the Contractor;

(2) not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive; and

(3) educate staff concerning its policies and procedures on Advance Directives.

Article 16
CONTRACTOR ASSURANCES

16.1 **Nondiscrimination.** The Contractor shall designate a nondiscrimination coordinator who shall:

(1) ensure the Contractor complies with federal laws and regulations regarding nondiscrimination;

(2) take Grievances from Enrollees alleging nondiscrimination violations as defined in Section 1557 of the Affordable Care Act and 42 CFR § 438.3(d)(4); and

(3) be permitted to handle Grievances regarding the violation of other civil rights, as other federal laws and regulations protect against these forms of discrimination.

16.2 **Written Policies Requirement.** The Contractor shall have written policies and procedures to implement Section 1557 of the Affordable Care Act.

16.3 **Member Services Function.** The Contractor shall:

(1) operate a Member Services function during Mountain Time regular business hours;

(2) provide ongoing training as necessary to ensure that the Member Services staff is conversant in the Contractor's policies and procedures as they relate to Enrollees; and

(3) ensure that Member Services staff at a minimum, are responsible for:

(A) explaining the Contractor's rules for obtaining services; and

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

16.4 **Provider Services Function.** The Contractor shall:

(1) operate a Provider services function during Mountain Time regular business hours; and

(2) ensure that Provider services staff, at a minimum, are responsible for:

(A) training, including ongoing training, of the Contractor's Providers on Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;

(B) assisting Providers to verify whether an individual is enrolled with the Contractor;

(C) assisting Providers with Service Authorization Requests and referral protocols;

(D) assisting Providers with Claims payment procedures, including training Providers on how to bill using the National Provider Identification (NPI) number or the DHHS-assigned atypical provider identification number that is known to Medicaid to avoid rejection of Encounter Data; and

(E) fielding and responding to Provider questions on the Grievance and Appeals System.

16.5 **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:

(A) DHHS does not pay the Contractor; or

(B) DHHS 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.

16.6 **Contractor Assurances Regarding Access.** The Contractor shall:

(1) provide DHHS assurances and supporting documentation that demonstrate the Contractor has the capacity to serve the expected enrollment in its Service Area with DHHS standards for access to care regarding appointment waiting times specified in Article 16.22 of this attachment;

(2) provide DHHS with documentation, in a format specified by DHHS, that the Contractor offers an appropriate range of Covered 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 needs of the anticipated number of Enrollees in the Service Area; and

(3) submit to DHHS the documentation assuring adequate capacity and services in the DHHS-specified format no less frequently than:

(A) at the time it enters into a contract with DHHS;

(B) on an annual basis; and

(C) at any time there has been a significant change (as defined by DHHS) 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 with the Contractor.

16.7 **Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers and Physical Disability.** The Contractor shall:

(1) actively identify, with a goal to eliminate Enrollee's access problems due to geographic barriers, cultural barriers, language barriers, and physical disabilities;

(2) provide assistance to Enrollees who have communications impediments or impairments to facilitate proper diagnosis and treatment;

(3) 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;

(4) accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990, as amended; and

(5) if the Contractor’s facilities are not accessible to Enrollees with physical disabilities, provide Covered Services in other accessible locations.

16.8 **Interpretive Services.** The Contractor shall:

(1) make oral interpretive services available free of charge for all non-English languages, not just those DHHS 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;

(2) use professional interpreters 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) 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;

(3) ensure that its Network Providers have interpreter services available and that nothing in this article may be construed to relieve Providers of their obligations to provide interpretive services under federal law; and

(4) cover interpretive services as described in the Utah Medicaid Provider Manual, and applicable MIB.

16.9 **Cultural Competence Requirements.** The Contractor shall:

(1) 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, or disabilities, and regardless of sex which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes;

(2) 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;

(3) 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;

(4) strive to ensure its Network Providers provide culturally competent services to Enrollees:

(5) have efforts to support cultural competency, including but not limited to, providing training to Network Providers regarding how to promote the benefits of Covered Services as well as training about health care attitudes, beliefs, and practices that affect access to or provision of Covered Services.

16.10 **No Restriction on Provider's Ability to Advise and Counsel.** The Contractor shall not:

(1) restrict a Provider's ability to advise and counsel Enrollees about Medically Necessary treatment options; and

(2) prohibit providers acting within their scope of practice, from freely advising Enrollees about their health status and discussing appropriate medical care or

treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

16.11 **Coordination and Continuity of Care.** The Contractor shall:

(1) implement procedures to deliver care and to coordinate Covered Services for all Enrollees. These procedures must:

(A) 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;

(B) ensure that each Enrollee is provided information on how to contact their designated person or entity; and

(C) ensure coordination of 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;

(2) 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;

(3) as appropriate, share with the DHHS 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;

(4) ensure that each Provider furnishing services to Enrollees maintains and shares an Enrollee health record in accordance with professional standards;

(5) 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; and

(6) not require its Network Providers to be responsible for rendering Home and Community-Based Waiver Services.

16.12 **Continuity of Mental Health Treatment or Services for a Child Leaving Foster Care.** The Contractor shall comply with Utah Code Ann. § 31A-22-663, and shall:

(1) upon an oral or written request of a Covered Child who is an Enrollee, offer a single case agreement that allows the Covered Child to receive covered Mental health Treatment or Services from a Covered Mental Health Therapist who is a Non-Network Provider, if:

(A) the Covered Child requests a single case agreement before the Covered Child receives Mental Health Treatment or Services from the Covered Mental Health Therapist, and provides documentation with the request for a single case agreement:

(i) that the Covered Child received Mental Health Treatment or Services from the Covered Mental Health Therapist while in the custody of DCFS; and

(ii) the date the Covered Child will leave or left the custody of DCFS.

(B) the Covered Child was in the custody of DCFS no more than 90 calendar days before the day on which the Covered Child requests the single case agreement; and

(C) the Covered Mental Health Therapist agrees to enter into the single case agreement;

(2) include in a single case agreement:

(A) that the reimbursement rate for the covered Mental Health Treatment or Services that will be provided by a Covered Mental Health Therapist who is a Non-Network Provider is the same reimbursement rate paid to Network Providers;

(B) any terms that a Network Provider is subject to; and

(C) the length and scope of the single case agreement;

(3) understand that nothing in Utah Code Ann. § 31A-22-665 may be construed to require the Contractor to pay a Covered Mental Health Therapist for services that are not otherwise covered under this contract; and

(4) as requested by DCFS, coordinate with DCFS to ensure continued provision of Mental Health Treatment or Services by the Covered Mental Health Therapist.

16.13 **Accountable Care Organizations.** When an Enrollee is also enrolled in an ACO, the Contractor and the ACO shall:

(1) share appropriate information regarding the Enrollee's health care to ensure coordination of all services rendered to the Enrollee; and

(2) not delay an Enrollee's access to needed services in disputes regarding responsibility for payment and shall address payment issues only after needed services are rendered.

16.14 **Network Provider Education on Care Coordination Model.** The Contractor shall:

(1) educate its Network Providers regarding an effective model of coordination between mental health, substance use disorder, and physical health care services; and

(2) require its Network Providers to coordinate the provision of mental health or substance use disorder services with physical health care services as appropriate.

16.15 **Rules for Enrollees with Special Health Care Needs.** DHHS shall identify Enrollees with Special Health Care Needs and the Contractor shall:

(1) have a mechanism in place to allow Enrollees with Special Health Care Needs to directly access a specialist;

(2) 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; and

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

16.16 **Contractor Follow-Up After Discharge from Psychiatric Hospitals or Mental Health Residential Treatment Programs that are IMDs.** In accordance with Article 5.3 of Attachment E, for Enrollees ages 21 through age 64, if the Contractor authorizes inpatient hospital psychiatric services in licensed and Medicare-certified psychiatric hospitals or authorizes treatment in licensed and accredited mental health residential treatment programs that are IMDs, and has not arranged follow-up Covered Services prior to discharge, then in accordance with Utah's Medicaid Reform 1115 Demonstration, the Contractor shall attempt to contact Enrollees within 72 hours of discharge to arrange services.

16.17 **Justice Re-Entry Initiative.** For Enrollees participating in the Justice Re-Entry Initiative, the Contractor shall comply with the Medicaid Justice-Involved Program Operational Guide and shall:

(1) participate in warm hand-off planning activities with the carceral facility or DHHS staff, and post-release case management services, including reviewing and updating assessments, which include an assessment of social determinants of health (SDOH), care planning, and assisting Enrollees to obtain needed services, including SDOH services identified in the assessments, for a period of 90 calendar days after the individual is released from a carceral facility and is enrolled with the Contractor;

(2) coordinate with the pre-release case managers to develop a warm hand-off process, which is initiated by the pre-release case manager, and includes engagement in meetings as often as needed as determined by the pre-release case manager, for the exchange of information;

(3) establish protocols to:

(A) contact the Enrollee on the day of release, or as soon as practicable after receiving notification of release from the carceral facility or DHHS;

(B) receive notification of release and the warm hand-off-related documents from the carceral facility or DHHS; and

(C) confirm information regarding scheduled appointments with the Enrollee;

(4) in collaboration with the Enrollee, make efforts to implement care plans, and after the initial in-network appointments scheduled by the pre-release case manager,

coordinate subsequent post-release appointments to provide for timely access to primary care services, mental health services, or substance use disorder services, as applicable, and make referrals to LTSS as applicable;

(5) continue to provide post-release case management services for 90 calendar days post-release from the carceral facility;

(6) assist Enrollees in having timely access to community-based organizations needed to carry out case management care plans as applicable, and to Providers with expertise in serving these Enrollees, particularly those with complex behavioral health and social needs;

(7) enter into a written agreement with the carceral facility that establishes responsibilities, protocols for protecting data, and cross-agency coordination. The written agreement should establish governance structure for information exchange on a regular cadence between the carceral facility and the Contractor including data needed to coordinate services post-release. The written agreement should also include that the carceral facility will facilitate obtaining releases of information when applicable in order to provide health information necessary for continuity of care post-release, while complying with HIPAA, 42CFR, and state privacy requirements; and

(8) submit to DHHS quarterly in a DHHS-specified report, the following metrics:

(A) the number of Justice-Involved Enrollees who received post-release case management;

(B) the number of Justice-Involved Enrollees who failed or declined to participate in post-release case management. This also includes if the Contractor attempted, but was unable to contact the Enrollee;

(C) the number of Justice-Involved Enrollees who accessed physical health care Covered Services within two business days post-release; and

(D) the number of Justice-Involved Enrollees who accessed mental health or substance use disorder Covered Services within 30 calendar days post-release.

16.18 **DHHS Notice of Justice Re-Entry Initiative Changes.** DHHS shall:

(1) at a minimum of 60 calendar days prior to the effective date, provide the Contractor with written notice of any new carceral facilities or programs which will be participating in the Justice Re-Entry Initiative, including the names and contact information for key staff at the carceral facility responsible for pre-release activities; and

(2) at a minimum of 60 calendar days prior to the effective date, provide the Contractor with written notice of any changes to the Medicaid Justice-Involved Program Operational Guide.

16.19 **Performance Standards for Timely Access.** The performance standards in this article govern the timeframes from the Initial Contact for offering the first Covered Service.

16.20 **Adherence to Performance Standards.** The Contractor shall comply with the performance standards in this article to ensure Enrollees have timely access to first Covered Services.

16.21 **Initial Contacts.** The Contractor shall:

(1) maintain an Initial Contact data system that allows the Contractor to document Initial Contacts and track and monitor adherence to the performance standards for offering first Covered Services;

(2) document and maintain Initial Contact data for the Enrollee whether the Contractor provides the first Covered Service directly or the Contractor refers the Enrollee to a Provider for the Covered Service, and the performance standards in this article apply; and

(3) not be required to document Initial Contact data and will not be held to the performance standards in this article when an Enrollee chooses to seek Covered Services directly from a Non-Network Provider and the Contractor authorizes the request.

16.22 **Performance Standards.** The Contractor shall:

(1) if it is determined during the Initial Contact that the Enrollee might require Emergency Services, conduct a clinical screening by telephone within 30 minutes and if is determined that the Enrollee has an emergency, offer outpatient

Emergency Services within one hour of completion of the telephone clinical screening;

(A) If an Initial Contact requiring outpatient Emergency Services is made on a walk-in basis, the Contractor shall offer outpatient Emergency Services within one hour;

(2) if it is determined during the Initial Contact that the Enrollee requires an Urgent Service, offer the first Covered Service within five business days of the Initial Contact and provide appropriate information regarding Emergency Services with instructions to contact the Contractor if more immediate services are needed;

(3) if it is determined during the Initial Contact that the Enrollee requires a Non-Urgent Service, offer the first Covered Service within 15 business days of the Initial Contact; or

(4) effective January 1, 2027, in accordance with Utah Code Ann. § 31A-22-663, when an Enrollee first seeks to access mental health or substance use disorder services, provide the first service in accordance with the Timely Manner timeframes and when applicable follow the requirements found in Article 8.7 of this attachment.

16.23 **Performance Standards Documentation Requirements.** The Contractor shall document:

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

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

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

(B) the date and time of the Emergency Services appointment offered (if applicable);

(3) the date and time of the Urgent Service and Non-Urgent Service appointment offerings for the first Covered Service;

(4) whether the Contractor is able to offer the first Covered Service within the required timeframe and if not, the reason;

(5) the status of scheduled first Covered Service appointments: if they are kept, broken, cancelled and/or rescheduled by the Enrollee, or rescinded and rescheduled by the Contractor due to Contractor limitations, and the date of any rescheduled appointments; and

(6) effective January 1, 2027, in accordance with Utah Code Ann. § 31A-22-663, and per the applicable Timely Manner timeframe, either the day, or the date and time that the Enrollee first attempts to access mental health or substance use disorder services, and the date and time of the first Covered Service.

16.24 **Notice of Adverse Benefit Determination.** The Contractor shall send the Enrollee a Notice of Adverse Benefit Determination when the Contractor:

(1) cannot offer the first Covered Service within the required timeframe, and the Enrollee is not satisfied with waiting beyond the required timeframe; or

(2) must rescind and reschedule a previously offered and scheduled appointment for the first Covered Service, and as a result will exceed the required timeframe, and the Enrollee is not satisfied with waiting beyond the required timeframe.

16.25 **Report of Performance.** The Contractor shall report performance against the performance standards using the DHHS-specified report.

16.26 **Billing Enrollees.** 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.

16.27 **Circumstances in Which an Enrollee May Be Billed.** An Enrollee may be billed for:

(1) services not covered under this Contract and not covered by Medicaid; or

(2) services covered under this Contract but not authorized by the Contractor.

16.28 **Requirements for Billing Enrollees.** 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 Article 16.27 of this attachment;

(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.

16.29 **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.

16.30 **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.

16.31 **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.

16.32 **Federal House Resolution 1 (H.R.1) Requirements.** Effective January 1, 2027, in accordance with Federal House Resolution 1 (H.R.1), the Contractor shall:

(1) support DHHS's efforts in implementing direct Enrollee support and Enrollee outreach; and

(2) report no less than weekly to DHHS, using the DHHS-specified pathway, any change in address information received directly from an Enrollee or verified by the Contractor directly with the Enrollee.

16.33 **Managed Care Transparency and Reporting Requirements.** The Contractor shall comply with Utah Code Ann. § 26B, Chapter 3, Part 12 and submit required reports and data in reporting formats and within timeframes specified by DHHS.

Article 17
PAYMENTS

17.1 **Payment Methodology.** The payment methodology is described in Attachment E.

17.2 **Contract Maximum.** In no event shall the aggregate amount of the payments made to the Contractor exceed this contract's maximum amount. If payments to the Contractor approach or exceed this amount before the renewal date of this contract, DHHS 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.

17.3 **Payment Recoupment.** DHHS 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 DHHS. Errors can include, but are not limited to, lack of eligibility or computer error.

17.4 **Contractor Disagreement with DHHS Determination.** If the Contractor disagrees with DHHS's determination that a payment was made in error, the Contractor may request an administrative hearing within 30 calendar days of DHHS's recoupment of the Overpayment.

17.5 **Overpayments.** The Contractor shall have written policies and procedures that specify:

(1) that the Contractor shall report to DHHS within 60 calendar days when it or any Subcontractor has identified Capitation Payments or other payments in excess of amounts specified in this 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 DHHS the recovery of Overpayments; and

(4) the process, timeframes, and documentation required for payment to DHHS of recoveries of Overpayments in situations where the Contractor is not permitted to retain some or all the recoveries of Overpayments.

17.6 **Mechanism for Provider Reporting Overpayments.** 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.

17.7 **Quarterly Overpayment Reports.** The Contractor shall submit to DHHS quarterly reports of Overpayments in the DHHS-specified report.

17.8 **Recovery and Retention of Overpayments.** The Contractor may collect and retain Overpayments from Providers. If Overpayments are related to Fraud, Waste, or Abuse, then Article 17.9 and Article 17.10 of this attachment apply.

17.9 **Collection and Retention of Overpayments Related to Fraud, Waste, or Abuse.** The Contractor may collect and retain Overpayments it recovers during the Recovery Period.

17.10 **Referral to the Utah OIG of Overpayments Related to Fraud, Waste, or Abuse.** The Contractor shall comply with the following conditions:

(1) 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;

(2) the Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries;

(3) 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:

(A) 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;

(B) the Contractor shall retain any Overpayments it has recovered; and

(C) the Utah OIG will retain its Overpayment recoveries;

(4) if the Contractor chooses not to pursue any Overpayment recoveries from a Provider, the Contractor shall refer the Overpayment to the Utah OIG. Utah OIG will retain its Overpayment recoveries; and

(5) if the Utah OIG identifies an unreported Overpayment, the Utah OIG will coordinate with the Contractor and may pursue collection of the Overpayment:

(A) the Utah OIG will retain its Overpayment recoveries.

17.11 **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 shall do no work on that part after the effective date of the loss of program authority. DHHS shall 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 DHHS 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 DHHS. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and DHHS 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.

17.12 **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 considered payment in full.

17.13 **Recovery of Third Party Liability.** The Contractor shall:

(1) make reasonable efforts to pursue the recovery of TPL for Covered Services provided to Enrollees:

(A) to assist the Contractor, the Enrollee Eligibility Transmission will include the other known Third Parties available to each Enrollee; and

(2) submit corrected Encounter Data to accurately reflect the TPL collection if the Contractor collects TPL on a Claim after the Encounter Data has been submitted to DHHS.

17.14 **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 USC § 1396(A)(25) and subpart D of 42 CFR § 433. The policies and procedures shall contain:

(1) procedures and mechanisms to identify potentially liable Third Parties:

(A) procedures and mechanisms shall include, at a minimum, verification of any Third Party coverage at the time of service; and

(B) when Enrollees obtain Covered Services from Providers not employed by the Contractor, that 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:

(A) 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; and

(B) the Contractor shall report changes to ORS either by email (TPLChanges@utah.gov) or by fax (801-536-8912).

17.15 **Cost Avoidance and Pay and Chase.** The Contractor shall:

(1) use reasonable efforts to evaluate the probable existence of TPL which exists where:

(A) the Contractor or Provider has confirmed that there was Third Party coverage in effect on the Enrollee's date of service; and

(B) the Contractor or Provider has determined that the Third Party will likely cover the service;

(2) except as otherwise provided in Article 17.15(3) of this attachment upon establishing the probable existence of TPL and if providing services directly, seek payment from the Third Party, or at the time a Provider files a Claim with the Contractor, reject the Claim and return it to the Provider for a determination of the amount of liability:

(A) the establishment of TPL takes place when the Contractor receives confirmation from the Provider or a Third Party resource indicating the extent of TPL; and

(B) in accordance with 42 CFR § 433.139, when the amount of liability is determined, the Contractor shall pay the Provider the difference between the Medicaid Fee Schedule and the contracted amount between the Third Party and the Provider;

(3) pay the Provider's Claim first and then seek reimbursement from the liable Third Party if:

(A) the Claim is for an EPSDT Enrollee (including preventative pediatric services), and is covered under the State Plan; or

(B) 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:

(i) 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; and

(4) 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.

17.16 **Discovery of TPL after Provision of Service or Claim Adjudication.** 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.

17.17 **Retention of TPL Payments.** The Contractor shall retain any payment it receives from TPL. Unless Article 17.16 of this attachment applies, the Provider shall retain any payment it receives stemming from TPL.

17.18 **Recovery of TPL Payments.** Recovery is not required when a Claim is $100 or less or $300 or less for cumulative Claims.

17.19 **Reporting TPL Payments.** The Contractor shall report TPL payments in the Encounter Data that are submitted to DHHS.

17.20 **Third Party Liability and Access to Care.** The Contractor shall:

(1) 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; and

(2) 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.

17.21 **Third Party Liability Exemptions.** The Contractor shall:

(1) not apply the TPL cost avoidance procedures outlined in Article 17.15(2) of this attachment to Claims for Covered Services that Third Parties generally do not cover:

(A) targeted case management for individuals with Serious Mental Illness; or

(B) Covered Services coded with Healthcare Common Procedure Coding System (HCPCS) H codes, unless (2) below applies; and

(2) apply TPL cost avoidance procedures outlined in Article 17.15(2) of this attachment to mental health and substance use disorder residential treatment services reported as per diem services, unless Article 17.15(3) of this attachment applies.

Article 18
CONTRACTOR'S PAYMENT RESPONSIBILITIES

18.1 **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 Article 1 of 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.

18.2 **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.

18.3 **Payment of Covered Services Due to Retroactive Coverage Due to Change in Program Type.** If a Medicaid Member was enrolled in a different MCE or FFS 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.

18.4 **Covered Services that are not the Contractor's Responsibility.** The Contractor shall not:

(1) 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 earthquakes or acts of war:

(A) 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;

(2) be required to pay for Covered Services provided to Indian Enrollees provided by IHCP. Such services are paid by DHHS;

(3) be required to pay for Covered Services provided by FQHCs. Such services are paid by DHHS; and

(4) be responsible to pay Crossover Claims. Such Claims shall be paid by DHHS.

Article 19

ENROLLEE TRANSITIONS BETWEEN MANAGED CARE ENTITIES OR FEE-FOR-SERVICE

19.1 **Transition of Care Policy.** The Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the DHHS-defined transition of care policy described in Article 19 of this attachment.

19.2 **Transitions During Inpatient Hospital Psychiatric Stays.** The Contractor shall:

(1) 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, be financially responsible for the entire inpatient hospital stay, including all services related to the hospital stay until discharged;

(2) not be financially 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:

(A) the entity in which the Medicaid Member was enrolled at admission to the hospital is financially responsible for the entire hospital stay, including all services related to the stay until the patient is discharged;

(3) be financially responsible for the inpatient hospital stay only for the period of Medicaid eligibility when an Enrollee is in an inpatient hospital setting and becomes ineligible for Medicaid any time prior to discharge from the hospital;

(4) be financially responsible for the inpatient hospital stay when an Enrollee in an inpatient hospital setting loses eligibility and then later becomes eligible retroactively for Medicaid, without a break in Medicaid coverage; and

(5) not be financially responsible for the inpatient hospital stay if an Enrollee is no longer Medicaid-eligible due to incarceration and is admitted for an inpatient hospital stay during the incarceration period.

19.3 **Transition of Services for Adult Expansion Enrollees.** If this Contract covers Adult Expansion Enrollees, for outpatient Covered Services, other than mental health or substance use disorder treatment in licensed residential treatment programs, and if these Enrollees were receiving outpatient Covered Services from Non-Network Providers through FFS or a UMIC Plan prior to enrollment with the Contractor, the Contractor shall reimburse the Non-Network Providers for continued outpatient Covered Services for up to 90 calendar days from the date of enrollment with the Contractor, unless the Enrollee chooses to transition to a Network Provider before the 90 calendar days have expired.

19.4 **Service Authorization for Licensed Mental Health and Licensed Substance Use Disorder Residential Treatment Programs.** The Contractor shall comply with the following requirements:

(1) when the Contractor has authorized treatment for an Enrollee in a residential treatment program and the Enrollee becomes enrolled in a different MCE or FFS any time prior to discharge from the program, the Contractor shall be financially responsible for the treatment only until the Enrollee becomes enrolled in a different MCE or FFS;

(2) when another MCE or DHHS has authorized treatment for a Medicaid Member in a residential treatment program and the individual becomes enrolled with the Contractor, the Contractor shall reimburse the Provider for the remainder of the Service Authorization given by the MCE or DHHS, or until the Enrollee is discharged from the Provider's program, whichever occurs first; and

(3) when an Enrollee has had a Third Party and that coverage terminates, and if the Contractor has not previously provided a Service Authorization, the Contractor shall allow a Provider to submit a Service Authorization Request for Covered Services dating back to the first date of service for which the Enrollee no longer had

a Third Party and shall pay for the remainder of the treatment episode as long as the treatment remains Medically Necessary.

19.5 **Contractor Adherence to Utah's Medicaid Reform 1115 Demonstration Requirements.** In accordance with Utah's Medicaid Reform 1115 Demonstration, if a Provider is a licensed mental health residential treatment program that is an IMD, all days for which the Contractor makes reimbursement count toward the 60-calendar day limit specified in Attachment E. This includes days for which the Contractor is the only payer and days for which the Contractor is the secondary payer to a Third Party's payment.

19.6 **Provision of Medical Information to DHHS or Other Managed Care Entities.** When an Enrollee is transitioned from the Contractor to FFS or to another MCE, the Contractor shall, upon a written request from DHHS or the Enrollee’s new MCE, submit the requested information up to five years after disenrollment.

19.7 **DHHS Requirement.** When an Enrollee is transitioned from FFS to the Contractor, DHHS shall, upon a written request, submit the requested information up to five years after disenrollment.

Article 20

INFORMATION SYSTEMS, RECORDKEEPING AND REPORTING REQUIREMENTS

20.1 **Health Information Systems.** In accordance with 42 CFR § 438.242, the Contractor shall:

(1) maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including utilization, Claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility;

(2) in accordance with Section 6504(a) of the Affordable Care Act and 42 CFR § 438.242, provide to DHHS all data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHHS to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act;

(3) collect data on Enrollee and Provider characteristics as specified by DHHS, and on all services furnished to Enrollees through an Encounter Data system or other methods as may be specified by DHHS;

(4) ensure that the data received from Providers are accurate and complete by:

(A) 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;

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

(C) 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; and

(5) make all collected data available to the DHHS and upon request to CMS, independent quality review examiners, and other Utah State agencies as allowed by law.

20.2 **Application Programming Interface (API) Requirements.** The Contractor shall:

(1) comply with 42 CFR § 431.70 where such requirements apply directly to the Contractor;

(2) implement and maintain a Patient Access API required in 42 CFR § 431.60 where such requirements applied directly to the Contractor;

(3) also comply with the other requirements in 42 CFR § 431.60, and per 42 CFR § 431.60(f), submit to DHHS the following metrics for the previous calendar year at the Contractor level in the form of aggregated, de-identified metrics:

(A) the total number of unique Enrollees whose data are transferred via the Patient Access API to a health app designated by the Enrollee; and

(B) the total number of unique Enrollees whose data are transferred more than once via the Patient Access API to a health app designated by the Enrollee;

(4) submit the metrics to DHHS in the DHHS-specified quarterly reports packet; and

(5) ensure that its API provides a complete and accurate provider directory that is updated no later than 30 calendar days after the Contractor determines a change in provider directory information is required.

20.3 **Accessible Content - Service Authorizations.** Beginning July 1, 2027, the Contractor's Patient Access API, shall contain service authorization information regarding Service

Authorization Requests and decisions for items and services (excluding drugs as defined 42 CFR § 431.60(b)(6)). The service authorization information shall include the following:

(1) the status of the Service Authorization Request;

(2) the date the Service Authorization Request was approved or denied;

(3) the date or circumstance under which the service authorization ends;

(4) the items and services approved;

(5) related structured administrative and clinical documentation submitted by a Provider; and

(6) if denied, a specific reason why the Service Authorization Request was denied.

20.4 **Accessibility of Service Authorization Information.** The Contractor shall ensure that its Service Authorization Request information is:

(1) accessible no later than one business day after the Contractor receives a Service Authorization Request;

(2) updated no later than one business day after any status change; and

(3) is accessible for the duration that the Service Authorization Request is active and at least one year after the Service Authorization Request's last status change.

20.5 **Enrollee Resources Regarding Privacy and Security.** The Contractor shall provide in an easily accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former Enrollees seeking to access their health information held by the Contractor, educational resources in non-technical, simple and easy-to-understand language that includes at a minimum:

(1) general information on steps the individual may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and

(2) an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to:

(A) the HHS Office for Civil Rights (OCR); and

(B) the Federal Trade Commission (FTC).

20.6 **Medical Records.** The Contractor shall:

(1) maintain a medical record keeping system that complies with State and federal law; and

(2) require its Network Providers to maintain a medical record keeping system that complies with State and federal law.

20.7 **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 including computer usage chargeback rates or composite fringe benefit rates.

20.8 **Record Retention Requirements.** The Contractor shall:

(1) unless otherwise specified by this contract or by federal or State law, 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 10.21 of this attachment, Contractor's policies and procedures, Contractor's Enrollee handbooks, and copies of reports required by DHHS; and

(2) retain and 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 and 438.610 for a period of no less than 10 years.

20.9 **Independent Financial Audit(s).** The Contractor shall submit its audited financial report to the DHHS within six months of the end of the Contractor's annual fiscal period. The audit shall be:

(1) specific to the Utah Medicaid contract;

(2) conducted in accordance with generally accepted accounting principles and generally accepted auditing standards; and

(3) conducted by an organization that has no internal ties to the Contractor.

20.10 **Report Due Dates.** The Contractor shall submit the reports on the dates specified by DHHS. If the due date falls on a weekend or on a State holiday, the report shall be due the following business day.

20.11 **DHHS-Required Reports.** The Contractor shall submit reports required in the PMHP Report Packet by the due date specified for each report included in the reports packet. The reports packet includes the following:

(1) Accreditation Summary;

(2) API Metrics;

(3) Appeals;

(4) Excluded Provider;

(5) Fraud Waste Abuse (FWA);

(6) Grievances;

(7) Justice Re-Entry;

(8) Manual Encounter Override Request;

(9) Non-Inclusion;

(10) Overpayments (non-FWA);

(11) Prior Authorization; and

(12) Service Verification.

20.12 **Additional Reporting Requirements.** The Contractor shall also submit the following reports to DHHS:

(1) a monthly electronic file of its Network Provider network that meets DHHS provider file specifications and data element requirements; and

(2) upon DHHS request and in a DHHS-specified format:

(A) medical management committee reports and minutes;

(B) customer service performance data as collected by the Contractor; and

(C) other reports deemed necessary (including any Enrollee or Provider satisfaction surveys conducted by the Contractor) to assess areas including access and timeliness or quality of care.

20.13 **Encounter Data.** The Contractor shall:

(1) in accordance with 42 CFR § 438.242(c), collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers Covered Services to Enrollees;

(2) transmit Encounter Data to DHHS using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR §§ 162.1101 and 162.1102;

(3) transmit all Encounter Data to DHHS, including allowed amount and paid amount, which DHHS is required to report to CMS under 42 CFR § 438.826;

(4) transmit all Encounter Data to DHHS in accordance with the X12 Standards for Electronic Data Interchange, Health Care Claim: 837 Institutional and Professional Guides as well as the DHHS 837 Companion Guides for Institutional and Professional Encounters, as amended;

(5) 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;

(6) if the Contractor is submitting an Encounter which was adjudicated by a Subcontractor, submit the Encounter Data within 30 calendar days of receipt from the Subcontractor if the Subcontractor does not submit the Encounter Data directly to DHHS;

(7) transmit Encounter Data for all services rendered to Enrollees under this contract, including:

(A) services for which the Contractor determined no liability exists;

(B) 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;

(C) services to Enrollees provided under a Capitation or special arrangement with another facility or program; and

(D) services provided to Enrollees who also have Medicare coverage when the Contractor provides services directly;

(8) submit corrections to all rejected Encounter Data within 45 calendar days of the date DHHS sends notice that the Encounter Data has been rejected;

(9) immediately notify DHHS and correct the Encounter Data 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; and

(10) be responsible for reviewing the 999, TA1, and 277 transactions and taking appropriate action when necessary.

20.14 **DHHS Responsibilities and Rights Regarding Encounter Data.** DHHS shall:

(1) edit Encounter Data in accordance with HIPAA standards and DHHS instructions and reject Encounter Data that are incomplete or that includes incorrect codes;

(2) 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 and send the Contractor a 277 Health Care Claim Status Response Transaction advising the Contractor of the status of the processed Claims; and

(3) have the right to require corrective action if the Contractor fails to transmit at least 95 percent of its Encounter Data within the timely submission standard in Article 20.13(5) of this attachment.

20.15 **Non-Enrollee Encounter Data.** The Contractor shall not submit Encounter Data when services performed by the Contractor were for HOME program Enrollees.

20.16 **Encounter Data Validation.** The Contractor shall:

(1) conduct quarterly Encounter Data validations:

(A) to facilitate the validation, DHHS 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; and

(2) respond to the DHHS Encounter Data validation questionnaire within 14 calendar days from the date DHHS sends the questionnaire and the Encounter Data submission detail file.

20.17 **Encounter Data Corrective Action.** If the Contractor fails to comply with the Encounter Data validation process, DHHS may require corrective action.

20.18 **Encounter Data for Rate Setting.** DHHS shall use for rate setting only the Encounter Data received by DHHS's deadline.

20.19 **Contractor Requirements for Encounter Submissions on Incorrectly Paid Claims.** For incorrectly paid Claims, which include but are not limited to Claims which were duplicative, overpaid, or disallowed, the Contractor shall:

(1) 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;

(2) 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;

(3) correct any Encounter Data for any incorrectly paid Claim regardless of whether the Contractor is successful in collecting the payment from the Provider; and

(4) make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

(A) the Provider has submitted a Claim for the date of service within 12 months of the date of service;

(B) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had TPL that should have paid on the Claim;

(C) 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

(D) absent the coordination of benefits issues or the timely filing issues, the Claim is otherwise payable.

20.20 **DHHS Sanctions Related to Encounter Data.** Failure to properly reverse or adjust Encounter Data shall result in sanctions allowed by Article 22 of this attachment.

20.21 **Medical Loss Ratio.** The Contractor shall:

(1) calculate and submit to DHHS an annual MLR consistent with the MLR standards found Article 20.21 of this attachment and DHHS MLR instructions document. DHHS shall make a good faith effort to give the Contractor any supplemental instructions 90 calendar days in advance of the MLR calculation being due; and

(2) create separate MLR data for the Legacy Medicaid Population eligibility groups and the Adult Expansion Population eligibility groups covered under the Contract.

20.22 **Medical Loss Ratio, Calculations.** The Contractor shall ensure:

(1) that the MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in 42 CFR § 438.8(e)) to the denominator (as defined in 42 CFR § 438.8(f));

(2) that each expense is 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;

(3) expenditures that benefit multiple contracts or populations, or contracts other than those being reported, are reported on a pro rata basis;

(4) the expense allocation is based on a generally accepted accounting method that is expected to yield the most accurate results;

(5) that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense;

(6) that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of Claims, are borne solely by the reporting entity and are not apportioned to the other entities; and

(7) that the MLR calculation only includes shared savings payments, profit sharing payments, etc. where:

(A) the payments require Network Providers to improve their performance on clinical or quality improvement standards or metrics;

(B) the performance period aligns with the MLR reporting period;

(C) the Network Provider agreements outlining the payments are signed before the start of the performance period; and

(D) the payments are not directly or indirectly based on the PMHP's MLR or profitability, as determined by DHHS.

20.23 **Medical Loss Ratio, Credibility Adjustment.** The Contractor shall comply with the following conditions regarding MLR credibility adjustments:

(1) the Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible;

(2) if required by DHHS, the Contractor shall add a credibility adjustment to the reported MLR calculation before calculating any remittances; and

(3) the Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

20.24 **Presumption of MLR Compliance for Non-Credible Experience.** If the Contractor’s experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

20.25 **Medical Loss Ratio, Reporting.** The Contractor shall:

(1) submit a MLR report to DHHS that includes for each MLR reporting year:

(A) total incurred Claims which include the amount of incentive and bonus payments made, or expected to be made, to Network Providers that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers as described in 42 CFR § 438.8(e)(2)(iii)(A);

(B) expenditures directly related to activities that improve health care quality, as such activities are described in 45 CFR § 158.150;

(C) expenditures related to Fraud prevention activities as defined in 42 CFR § 438.8(e)(4);

(D) non-Claim costs;

(E) premium revenue;

(F) taxes;

(G) licensing fees;

(H) regulatory fees;

(I) methodologies for allocation of expenditures which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR § 158.170(b);

(J) any credibility adjustment applied;

(K) the calculated MLR;

(L) any remittance owed to DHHS (if applicable);

(M) a comparison of the information reported with the audited financial report;

(N) a description of the aggregation method used to calculate total incurred Claims; and

(O) the number of member months;

(2) submit the MLR report in a DHHS-specified format no later than January 31st of each year, unless an alternative date is agreed to by the Parties;

(3) 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;

(4) at the request of DHHS, recalculate the MLR for all MLR reporting years and submit a new MLR report meeting the applicable requirements in any instance where DHHS makes a retroactive change to the Capitation Payments for an MLR reporting year where the MLR report has already been submitted to DHHS; and

(5) attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

20.26 **Data Submission.** The Contractor shall:

(1) submit the following data to DHHS:

(A) Encounter Data in the form and manner described in 42 CFR § 438.818 and this contract;

(B) data on the basis of which DHHS 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;

(C) data on the basis of which DHHS determines the compliance of the Contractor with the MLR requirement described in this contract and 42 CFR § 438.8;

(D) data on the basis of which DHHS determines that the Contractor has made adequate provision against the risk of insolvency as required under this contract and 42 CFR § 438.116; and

(E) documentation described in 42 CFR § 438.207(b) on which DHHS bases its certification that the Contractor has complied with DHHS's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR § 438.206; and

(2) submit any other data, documentation, or information relating to the performance of the Contractor's obligations under 42 CFR § 438 as required by DHHS or the Secretary of HHS.

20.27 **Data Certification.** The Contractor shall comply with the following requirements:

(1) by submitting data, documentation, or information described in Article 20.26 of this attachment to DHHS, the Contractor certifies and attests that, based on best information, knowledge, and belief, the data, documentation, and information are accurate, complete, and truthful;

(2) the Contractor shall certify in writing, at the time it submits the data, reports, and disclosures to DHHS in accordance with Article 16.32 of this attachment and Utah Code Ann. § 26B-3-1203, that the data, reports, and disclosures are accurate and complete.

20.28 **Additional Data Certification.** When required by DHHS, one of the following individuals shall also attest that, based on the best information, knowledge, and belief, the data, documentation, or information required by Article 20.26 of this attachment are accurate, complete, and truthful:

(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.

20.29 **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 and shall report the following information:

(1) a list of all Covered Services that require service authorization;

(2) Standard Service Authorization Requests:

(A) the percentage of standard Service Authorization Requests that were approved, aggregated for all Covered Services;

(B) the percentage of standard Service Authorization Requests that were denied, aggregated for Covered Services;

(C) the percentage of standard Service Authorization Requests that were approved after an Appeal decision, aggregated for Covered Services;

(D) 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

(E) 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:

(A) the percentage of expedited Service Authorization Requests that were approved, aggregated for all Covered Services;

(B) the percentage of expedited Service Authorization Requests that were denied, aggregated for all Covered Services;

(C) the percentage of expedited Service Authorization Requests that were approved after an Appeal decision, aggregated for all Covered Services;

(D) 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

(E) 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 21
COMPLIANCE AND MONITORING

21.1 **Inspection and Audit of Financial Records.** The DHHS 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 this contract; or

(3) any other audit allowed by State or federal law.

21.2 **Contractor Requirements for Inspections and Audits.** The Contractor shall:

(1) make available to the DHHS, 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; and

(2) in accordance with 45 CFR § 74.48 (except for those contracts for 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.

21.3 **Additional Contractor Requirements for Inspections and Audits.** The Contractor shall:

(1) place no restrictions on the right of the DHHS, 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;

(2) permit inspection and audit methods that may 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; and

(3) permit DHHS, CMS, the Utah OIG, the Comptroller General, and their designees at any time to 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 are conducted.

(A) 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.

21.4 **Management and Utilization Audits.** The Contractor shall:

(1) allow the DHHS, 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 and exception reports; and

(2) provide all data required by the DHHS, the federal government, independent quality review examiners, and other State agencies allowed to conduct such audits.

21.5 **Utah Office of Inspector General.** The Contractor shall:

(1) 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);

(2) provide to the Utah OIG any record requested by the Utah OIG in accordance with Utah Code Ann. § 63A-13-301;

(3) cooperate with the Utah OIG with respect to an audit or investigation as required by Utah Code Ann. §§ 63A-13-302 and 63A-13-303;

(4) in accordance with Utah Code Ann. § 63A-13-304, not interfere with a Utah OIG audit or investigation;

(5) comply with all subpoenas from the Utah OIG that are properly issued in accordance with Utah Code Ann. § 63A-13-401; and

(6) allow the Utah OIG to conduct announced or unannounced site visits in accordance with Utah Code Ann. § 63A-13-302, Utah Administrative Rule R30-1-6, and 42 CFR § 455.432.

Article 22
CORRECTIVE ACTION AND SANCTIONS

22.1 **Corrective Action Plans.** In the event that the Contractor fails to comply with its obligations under this contract, DHHS may:

(1) impose a corrective action plan to cure the Contractor's non-compliance; and

(2) at DHHS discretion, develop the corrective action plan or require the Contractor to submit a corrective action plan.

22.2 **DHHS-Issued Corrective Action Plan.** If DHHS develops a corrective action plan, DHHS shall provide it to the Contractor in writing, and the Contractor shall:

(1) comply with the terms of a DHHS-issued corrective action plan and shall complete all required actions within the required timeframes. DHHS shall provide the Contractor with a reasonable amount of time to complete the corrective action plan; and

(2) be permitted to file a request for an administrative hearing within 30 calendar days of receipt of DHHS's corrective action plan if the Contractor disagrees with the DHHS's corrective action plan.

22.3 **Contractor Generated Corrective Action Plans.** If DHHS requires the Contractor to create its own corrective action plan, DHHS shall send a written notice to the Contractor detailing the Contractor's non-compliance and requiring the Contractor to develop a corrective action plan.

22.4 **Timeframe for Submission of Corrective Action Plan.** Unless otherwise specified in the notice from DHHS, the Contractor shall have 20 business days from the date DHHS's notice was mailed to submit a corrective action plan to DHHS for its approval.

22.5 **Corrective Action Plan Review and Approval.** DHHS shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 calendar days of receipt. In the event DHHS determines that the Contractor's corrective action plan needs to be revised, DHHS 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 DHHS if DHHS fails to respond to the Contractor within 20 calendar days of receipt of the Contractor's corrective action plan.

22.6 **Corrective Action Plan Implementation.** The Contractor shall comply with the terms of a DHHS-approved corrective action plan and shall complete all required actions within the required timeframes.

22.7 **DHHS Procedures and Remedies for Contractor Non-Compliance with the Contract.** The Contractor shall be subject to the following procedures and remedies:

(1) in the event that the Contractor fails to comply with its obligations under this contract, DHHS shall provide the Contractor with 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:

(A) if DHHS decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, DHHS shall provide the Contractor with at least 30 calendar days to cure its non-compliance. However, DHHS may shorten the 30 calendar day period in the event that a delay would endanger an Enrollee's health, or the timeframe must be shortened in order for DHHS and the Contractor to meet federal guidelines;

(2) if the Contractor fails to cure the non-compliance as ordered by DHHS and within the timeframes designated by DHHS, DHHS may, at its discretion, impose any or all the following sanctions:

(A) suspension of the Contractor's Capitation Payment;

(B) assessment of civil monetary penalties; or

(C) imposition of any other sanction allowed by federal and State law; and

(3) DHHS's imposition of any of the sanctions described in Article 22.7(2) of this attachment is not intended to be an exclusive remedy available to DHHS. The assessment of any of the sanctions listed in Article 22.7(2) of this attachment in no way limits additional remedies, at law or at equity, available to DHHS due to the Contractor's breach of this contract.

22.8 **DHHS Suspension of Capitation Payments.** In addition to other remedies allowed by law and unless specified otherwise, DHHS 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 DHHS for any reason; or

(4) fails to submit or comply with a corrective action plan within the timeframes required by DHHS.

22.9 **DHHS Written Notice Prior to Capitation Payment Suspension.** DHHS shall provide written notice ten calendar days prior to the suspension of Capitation Payments and shall include in the notice the reason for the suspension and the action the Contractor

must take to receive payment and the timeframe in which the Contractor must take action to avoid suspension of the Capitation Payment.

22.10 **Contractor Failure to Cure Deficiency.** If the Contractor fails to cure the deficiency, DHHS may continue the suspension of Capitation Payments until the Contractor comes into compliance.

22.11 **Resumption of Capitation Payments after Suspension.** Upon the Contractor achieving compliance, DHHS shall remove the suspension of Capitation Payments and in the next regular payment cycle:

(1) remit the previously suspended Capitation Payments; and

(2) resume Capitation Payments.

22.12 **DHHS Suspension of Capitation Payments due to Missing State Match.** DHHS may suspend Capitation Payments without prior notice if DHHS does not receive the State Match payment from the Local Mental Health/Substance Abuse Authority.

22.13 **Administrative Hearing for Capitation Payment Suspension.** 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 DHHS's notice of intent to suspend the Capitation Payments. DHHS may continue to withhold Capitation Payments through the duration of the administrative hearing, unless ordered by the hearing officer to release the Capitation Payments.

Article 23
TERMINATION OF THE CONTRACT

23.1 **Automatic Termination.** This contract shall automatically terminate on June 30, 2031.

23.2 **Contractor Termination Without Cause.** The Contractor may terminate this contract without cause by giving DHHS 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 of this contract effective no earlier than the first day of the third month following the Contractor’s written notice.

23.3 **DHHS Termination Without Cause.** DHHS may terminate this contract without cause upon 30 calendar days written notice to the Contractor.

23.4 **Effect of Automatic Termination or Termination Without Cause.** The Contractor shall:

(1) 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; and

(2) upon any termination of this contract, promptly supply to DHHS all information it requests regarding paid and unpaid Claims.

23.5 **Non-Liability of Enrollees.** 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.

23.6 **CMS Direction to Terminate.** In the event that CMS directs DHHS to terminate this contract, DHHS shall not be permitted to renew this contract without CMS consent.

23.7 **Contractor Close Out Duties.** 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.

23.8 **Transition Plan.** In the event of termination of this contract, the Contractor shall work with DHHS 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 DHHS;

(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 DHHS with complete and accurate Encounter Data for all Encounters generated during the lifetime of this contract;

(4) providing DHHS with reports as required by this contract and any other ad-hoc reports required by DHHS;

(5) complying with any audit requests; and

(6) orderly and reasonable transfer of care for Enrollees.

23.9 **Cessation of Enrollment and Future Capitation Payments.** With the exception of retroactive Capitation Payments, DHHS shall cease enrollment of Medicaid Individuals and Capitation Payments for dates following the termination of this contract.

23.10 **Post-Termination Payments and Erroneous Payment Notification.** The Contractor shall not accept any payments from DHHS after the termination of this contract, unless payment is for the time period covered under this contract. If the Contractor determines DHHS has made a payment in error, the Contractor shall notify DHHS in accordance with Article 17.5 of this attachment.

23.11 **Withholding of Payment Pending Required Documentation.** DHHS may withhold any payments due under this contract until DHHS receives from the Contractor any written and properly executed documents as required by written instructions from DHHS.

23.12 **Breach of Contract and Opportunity to Cure.** Failure of the Contractor to comply with the provisions found in Article 23.7 of this attachment shall be deemed a breach of contract and DHHS may exercise any remedy available under this contract or by operation of law. DHHS 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 this contract.

Article 24
MISCELLANIOUS PROVISIONS

24.1 **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, if there is a conflict between this

Attachment B, Scope of Work, and Attachment A, General Provisions, then this Attachment B shall control.

24.2 **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.

24.3 **DHHS Interpretation of Laws and Regulations.** DHHS 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 DHHS. DHHS shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of federal and State law.

24.4 **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.

24.5 **Assignment.** Assignment of any or all rights or obligations under this contract without the prior written consent of DHHS 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 DHHS's sole and absolute discretion.

24.6 **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 DHHS has paid monthly Capitation Payments to the Contractor.

24.7 **Policy, Rules, and Regulations.** The Contractor shall be aware of, comply with, and be bound by:

(1) the State Plan, DHHS’s 1915(b) Prepaid Mental Health Plan Waiver, Utah's Medicaid Reform 1115 Demonstration, and DHHS'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; and

(2) 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.

24.8 **Solvency Standards.** Unless exempt, the Contractor shall:

(1) comply with 42 CFR § 438.116 and provide assurances satisfactory to DHHS 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; and

(2) comply with 42 CFR § 438.116(b)(2) and meet the solvency standards required by 42 CFR § 438.116(b)(1).

24.9 **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.

24.10 **CMS Approval of Contract.** The Contractor understands and agrees that this contract is subject to approval by CMS. The Contractor agrees to execute any amendment necessary to make this contract compliant with any CMS requirements. The Contractor shall be responsible for repayment of any disallowances of FFP in the event the Contractor refuses to execute a contract amendment to bring this contract into compliance with any CMS requirements.

24.11 **Duty to Maintain Data Confidentiality.** The Contractor shall maintain the confidentiality of any Confidential Data that it receives from DHHS 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.

24.12 **Network Security.** For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain:

(1) at all times, network security that at minimum, includes network firewall provisioning, intrusion detection and regular third party penetration testing; and

(2) network security that conforms to:

(A) standards which the State applies to its own network as found at http://dts.utah.gov/policies;

(B) current standards set forth and maintained by the National Institute of Standards and Technology; or

(C) any industry-accepted standards that are comparable to those described in Article 24.12(A)(2) or Article 24.12(B)(2) of this attachment.

24.13 **Data Security.** The Contractor shall:

(1) protect and maintain the security of Confidential Data with protection that conforms to:

(A) standards that are at least as good as or better than those maintained by the State of Utah found at http://dts.utah.gov/policies;

(B) current standards set forth and maintained by the National Institute of Standards and Technology; or

(C) any industry accepted standards that are comparable to those described in Article 24.13(A)(1) or Article 24.13(B)(1) of this attachment;

(2) develop and use appropriate administrative, technical, and physical security measures to preserve the confidentiality and integrity of all electronically maintained or transmitted Confidential Data; and

(3) ensure the 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.

24.14 **Data Transmission.** The Contractor shall ensure that any transmission or exchange of Confidential Data to DHHS shall take place via secure means, such as HTTPS, SFTP, or FTPS.

24.15 **Data Storage.** The Contractor shall:

(1) ensure that any Confidential Data is 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 laptop, portable computing device, cell phone, or any unencrypted portable storage medium; and

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

24.16 **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.

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

24.18 **Extension of Confidentiality and Data Security Requirements to Subcontractors.** The Contractor shall extend the duty of confidentiality found in Article 24.11 of this attachment and the Confidential Data requirements found between Article 24.12 and Article 24.17 of this attachment to all Subcontractors used by the Contractor.

24.19 **Contractor Access to State Databases.** The Contractor shall:

(1) maintain a log of all Employees or Subcontractors with access to any database maintained by DHHS or the State to whom DHHS has given access;

(2) notify DHHS within two business days when an Employee or Subcontractor with access to a database maintained by DHHS or the State no longer requires access to the database; and

(3) on an annual basis, provide to DHHS a log of all Employees or Subcontractors with access to a DHHS or State-maintained database, and in submitting the log to DHHS,

certify that the job duties of each Employee or Subcontractor named in the log require that the Employee or Subcontractor have access to a DHHS or State-maintained database.

24.20 **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.

24.21 **Telephone Consumer Protection Act (TCPA).** The Contractor shall:

(1) 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; and

(2) be 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 **Requirements for Covered Services.** The Contractor shall:

(1) administer Covered Services in accordance with DHHS's Medicaid provider manuals. These Medicaid provider manuals provide detailed information regarding Covered Services and are available to the Contractor on DHHS's website;

(2) agree that the State Plan, DHHS's 1915(b) waivers, Utah's Medicaid Reform 1115 Demonstration, DHHS's provider manuals, MIBs, and Coverage and Reimbursement Code 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, DHHS's 1915(b) waivers, Utah's Medicaid Reform 1115 Demonstration, DHHS's provider manuals, MIBs, and Coverage and Reimbursement Look-up Tool, DHHS retains the right to determine whether the services are Covered Services under this contract; and

(3) agree that DHHS shall have the right to interpret the publications specified in Article 1.1(2) of this attachment.

1.2 **Service Limitations.** The Contractor shall ensure that:

(1) Covered Services can only be limited through utilization criteria based on Medical Necessity; and

(2) Covered Services are of a quality that meets professionally recognized standards of health care and shall be substantiated by records that include evidence of Medical Necessity and quality, and shall make the records available to DHHS upon request.

1.3 **Inpatient Hospital Psychiatric Services.** In accordance with Attachment B, inpatient hospital psychiatric services are Poststabilization Care Services performed on an inpatient basis under the direction of a physician for a psychiatric condition manifesting itself with a sudden onset. At the time of the inpatient admission, the psychiatric condition should be of such a nature as to pose a significant and immediate danger to self, others, or public safety, or one which has resulted in marked psychosocial dysfunction or grave mental disability. Inpatient hospital psychiatric services must be

based on a plan of care and involve active psychiatric treatment which is reasonably expected to improve the patient's psychiatric condition or prevent further regression.

1.4 **Contractor Responsibility for Payment.** The Contractor shall:

(1) pay for inpatient hospital psychiatric services regardless of where the service was delivered in the acute inpatient hospital;

(2) be responsible for inpatient hospital psychiatric services for Enrollees regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder, intellectual disability, an organic disorder, or a substance use disorder;

(3) cover history and physical examinations and physician rounds conducted during an inpatient hospital psychiatric admission; and

(4) be responsible for payment of all services related to the inpatient admission if the Contractor authorizes an Enrollee for inpatient hospital psychiatric services.

1.5 **Outpatient Mental Health and Substance Use Disorder Services.** The following services are Covered Services under this contract:

(1) psychiatric diagnostic evaluation, except as described in the Carved-Out Services section in this attachment;

(2) mental health assessment by a non-mental health therapist;

(3) psychological testing, except as described in the Carved-Out Services section in this attachment;

(4) psychotherapy with patient;

(5) psychotherapy when performed with an evaluation and management (E/M) service;

(6) family psychotherapy with patient present;

(7) family psychotherapy without patient present;

(8) multiple family group psychotherapy;

(9) group psychotherapy (other than a multiple family group);

(10) psychotherapy for crisis;

(11) evaluation and management (E/M) services (pharmacologic management);

(12) nurse medication management and injection procedure;

(13) individual and group therapeutic behavioral services;

(14) individual and group psychosocial rehabilitative services;

(15) peer support services;

(16) Assertive Community Treatment (ACT) if the Contractor provides Covered Services through an ACT team (bundled service);

(17) Mobile Crisis Outreach Team (MCOT) if the Contractor provides Covered Services through an MCOT (bundled service);

(18) substance use disorder treatment in a licensed substance use disorder residential treatment program. Services are limited to members age 12 and older;

(19) mental health treatment in a licensed mental health residential treatment program. Licensed mental health residential treatment programs with 17 or more beds are limited to members age 21 and older;

(20) social detoxification (ASAM 3rd Edition, level 3.2 clinically managed residential withdrawal management or ASAM 4th Edition, level 3.7 medically managed residential treatment) (bundled service);

(21) outpatient detoxification (ASAM 3rd Edition, level 1 and level 2 ambulatory withdrawal management or ASAM 4th Edition, level 1.7 medically managed outpatient treatment and level 2.7 intensive medically managed outpatient treatment) (bundled service);

(22) recreational therapy services;

(23) Transcranial Magnetic Stimulation (TMS);

(24) electroconvulsive therapy (ECT), including any accompanying anesthesia and other related charges;

(25) psychiatric services rendered by a psychiatrist in the emergency room to assess a mental health disorder or substance use disorder;

(26) supportive living; and

(27) targeted case management for individuals with serious mental illness.

1.6 **General Medical Consultations and Neurological Examinations.** The Contractor shall cover these services when they are Medically Necessary to assist in diagnosing a mental health disorder or substance use disorder.

1.7 **Co-occurring Disorders.** The Contractor shall be responsible for outpatient Covered Services regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder, intellectual disability, or an organic disorder.

1.8 **Behavioral Health Evaluations Ordered by Courts or DHHS.** Evaluations requested by a court or DHHS to determine if a child Enrollee or their parent who is an Enrollee has a diagnosis of a mental health or substance use disorder and to recommend a course of treatment are Covered Services, except for Enrollees who are K Children.

1.9 **1915(b)(3) Services.** Services designated as 1915(b)(3) services are Covered Services for Enrollees with Capitation Payments for inpatient and outpatient Covered Services. The following services are 1915(b)(3) services or additional services:

1.10 **Adult Expansion Members.** If Adult Expansion members are enrolled with the Contractor, in accordance with Utah's Medicaid Reform 1115 Demonstration that allows additional services (which are the same services as 1915(b)(3) services authorized under the PMHP waiver), additional services are Covered Services. The following services are 1915(b)(3) services or additional services:

(1) psychoeducational services;

(2) personal services; and

(3) respite care.

1.11 **Coverage of Services for K Children.** The Contractor shall:

(1) be responsible for payment of inpatient hospital psychiatric services for K Children; and

(2) not be responsible for outpatient Covered Services for K Children. These services are carved out of this Contract.

1.12 **Enrollees in Nursing Facilities or Receiving Home and Community-Based Waiver Services.** The Contractor shall:

(1) provide Covered Services to Enrollees in nursing facilities, including intermediate care facilities for intellectual disabilities (ICFs/ID), and Enrollees in Home and Community-Based Services waiver programs; and

(2) be responsible for coordinating treatment planning and service delivery with the nursing facility, ICF/ID or waiver organization to ensure timely delivery of Covered Services to the Enrollee.

1.13 **EPSDT Services.** The Contractor shall provide mental health and substance use disorder services to EPSDT Enrollees in accordance with 42 USC § 1396d(r).

1.14 **Non-Emergency Transportation Services.** The Contractor:

(1) may, at the Contractor's discretion, directly provide non-emergency transportation to Covered Services provided in an outpatient setting. When the Contractor directly provides non-emergency transportation, it is also a Covered Service under this contract; and

(2) shall not be responsible for non-emergency transportation for:

(A) Enrollees who are using DHHS's non-emergency medical transportation provider for transportation to Covered Services in an outpatient setting; and

(B) Enrollees seeking to access public transportation.

1.15 **Carved Out Services.** The Contractor shall not be responsible to cover the following services:

(1) inpatient hospital services for treatment of substance use disorders, including medical detoxification;

(2) methadone administration (including the medication and the provision of the medication by a licensed opioid treatment program [OTP]);

(3) behavioral health evaluations requested by a court or DHHS's Division of Child and Family Services, solely for the purpose of determining if an Enrollee who is a parent is able to parent and should therefore be granted custody or visitation rights. These evaluations are also not covered by FFS;

(4) behavioral health evaluations or reevaluations requested by DWS or DHHS to determine disability related to Medicaid eligibility. Such services shall be paid by DHHS;

(5) psychiatric services ordered by an Enrollee's physician while hospitalized in a non-psychiatric unit of a hospital;

(6) inpatient and outpatient Covered Services for the evaluation or treatment of an Enrollee's developmental disability, intellectual disability, or organic disorder;

(7) mental health evaluations and psychological testing performed for physical health purposes, including prior to medical procedures;

(8) emergency medical transportation to inpatient hospital psychiatric services;

(9) pharmacy, except when Article 1.4(4) of this attachment applies;

(10) consultation provided by a psychiatrist to an Enrollee's treating physician. For reimbursement the psychiatrist must bill their services FFS using the codes in the Telepsychiatry section of the Utah Medicaid Provider Manual;

(11) Autism Spectrum Disorder (ASD) services;

(12) services to residents of the Utah State Developmental Center or the Utah State Hospital;

(13) behavioral health receiving centers;

(14) behavioral health services provided by an FQHC; and

(15) Employment-related Personal Assistant Services (EPAS).

Article 2
COST SHARING

2.1 **Enrollees Exempt from Cost Sharing.** 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.

2.2 **Copayments.** There are no copayments for outpatient Covered Services. There is a $75 copayment for each inpatient hospital stay unless the Enrollee is in a group found in Article 2.1 of this attachment that is exempt from all cost sharing requirements.

Attachment D - QUALITY AND PERFORMANCE

Article 1

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

1.1 **Quality Assessment and Performance Improvement.** In accordance with 42 CFR § 438.330, the Contractor shall have an ongoing comprehensive QAPIP for the services it furnishes to its Enrollees.

1.2 **QAPIP Requirements.** The QAPIP shall include a policymaking body that oversees the QAPIP. A designated senior official shall be responsible for the 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.

1.3 **CMS Quality Requirements.** 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.

1.4 **Basic Elements of Quality Assessment and Performance Improvement Programs.** At a minimum, the Contractor shall establish and maintain a QAPIP that includes at least the following elements:

(1) PIPs in accordance with Article 1.6 of this attachment;

(2) collection and submission of performance measurement data in accordance with Article 1.7 of this attachment;

(3) mechanisms to detect both underutilization and overutilization of services; and

(4) mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs as defined in the DHHS's Managed Care Quality Strategy.

1.5 **QAPIP Plan and Submission.** The Contractor shall:

(1) maintain a written QAPIP plan that addresses Article 1.1 and Article 1.4 of this attachment;

(2) submit a written QAPIP Program Description to DHHS by February 1, or a mutually agreed upon date, of the first year in a Contract cycle. In subsequent years of the Contract, the Contractor shall submit to DHHS its QAPIP Program Description if it has changed from the last submission; and

(3) annually submit the following QAPIP-related documents to DHHS in a DHHS-specified format:

(A) the Contractor's quality improvement work plan for the current calendar year; and

(B) the Contractor's quality improvement work plan evaluation for the previous calendar year.

1.6 **Performance Improvement Projects.** The Contractor shall:

(1) have ongoing PIPs that focus on clinical and nonclinical areas, including any PIPs required by CMS or DHHS;

(2) ensure that each PIP be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and that include:

(A) measurement of performance using objective quality indicators;

(B) implementation of interventions to achieve improvement in the access to and quality of care;

(C) evaluation of effectiveness of the interventions based on the performance measures specified in Article 1.6(A)(2) of this attachment; and

(D) planning and initiation of activities for increasing or sustaining improvement;

(3) before implementing a new PIP, submit the topic to DHHS for approval using a format specified by DHHS;

(4) report the status and results of each PIP, including those required by CMS, to DHHS as requested by DHHS, but no less than once per year; and

(5) agree that DHHS may, at its discretion, establish a timeframe and deadline for the Contractor to complete a PIP.

1.7 **Performance Measurement Requirements.** Annually, the Contractor shall:

(1) measure and report to DHHS its performance using standard measures required by DHHS and/or CMS;

(2) submit to DHHS data specified by DHHS, using approved CMS reporting methods that enable DHHS to measure the Contractor's performance;

(3) perform a combination of the above activities;

(4) develop and implement a written plan for improvement when the reported performance on the performance measure specified in Article 2.2 of this attachment is lower than the previous year; and

(5) compile and submit its performance measures report for the preceding calendar year as specified by DHHS and the DHHS's EQRO.

Article 2

PERFORMANCE TRACKING AND MONITORING

2.1 **Performance Measures.** The Contractor agrees that:

(1) selected performance measures as specified in Article 2.2 of this attachment, shall be established by DHHS;

(2) DHHS may amend the performance measures found in Article 2.2 of this attachment. DHHS, when possible, shall consult with the Contractor prior to changing the reportable performance measures and, when possible, shall negotiate with the Contractor the effective date of any new performance measures; and

(3) DHHS may track, monitor trends, and publish the Contractor's performance measure targeted rates and performance rates.

2.2 **Performance Measures Table.** The Contractor shall comply with the following measures:

Measure Name	Responsible for Rate Calculation
HEDIS-FUH: Follow-Up After Hospitalization for Mental Illness	Contractor

Article 3

EXTERNAL QUALITY REVIEW

3.1 **External Quality Review Requirements.** The Contractor shall:

(1) agree that in accordance with 42 CFR § 438, subpart E, DHHS 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);

(2) maintain, and make available to the EQRO, all clinical and administrative records for use in EQRs;

(3) develop a corrective action plan to comply with the EQRO's required corrective actions;

(4) act in good faith to implement other recommendations resulting from the analysis required in Article 3.1(1) of this attachment; and

(5) support any additional quality assurance reviews, focused studies, or other projects that DHHS may require as part of EQRs.

3.2 **Contractor Staffing Requirements.** The Contractor shall:

(1) designate an individual to serve as a liaison for the EQRs; and

(2) designate representatives, as needed, including but not limited to, quality improvement representative and a data representative to assist with EQRs.

3.3 **Copies and On-Site Access.** The Contractor shall:

(1) be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during reviews;

(2) be responsible for Document copying costs;

(3) agree that 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;

(4) agree that onsite EQRs shall be performed during hours agreed upon by DHHS and the Contractor;

(5) assure adequate workspace, access to a telephone, and a copy machine for individuals conducting on-site EQRs; and

(6) assign appropriate staff to assist during EQRs.

3.4 **Timeframe for Providing Information.** The Contractor shall:

(1) provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by DHHS; and

(2) request an extension from DHHS if the Contractor cannot meet the timeframe for providing documentation. It shall be the discretion of DHHS to approve or disapprove the extension.

Article 4
MISCELLANEOUS QUALITY PROVISIONS

4.1 **Accrediting.** The Contractor shall:

(1) inform DHHS whether it has been accredited by a private independent accrediting entity; and

(2) if the Contractor has received accreditation by a private independent accrediting entity, provide DHHS with a copy of its most recent accreditation review, including:

(A) accreditation status, survey type, and level (as applicable);

(B) accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings; and

(C) expiration of the date of accreditation.

Attachment E - PAYMENT METHODOLOGY

Article 1
RISK CONTRACTS

1.1 **Risk Contracts Classification and Requirements.** This contract is classified as a Risk Contract. The Contractor shall:

(1) provide all services required by this contract;

(2) ensure that Capitation Paymentsand any cost sharing from Enrollees be considered payment in full for all services covered under this contract;

(3) incur loss if the cost of providing the services exceeds the payments under this contract;

(4) be permitted to retain all Capitation Payments made by DHHS, unless Article 2.7 of this attachment applies, and shall use them for Enrollees;

(5) in accordance with 42 CFR § 438.3(e), provide services to Enrollees that are in addition to those coveredunder the State Plan. The cost of these services cannot be included when determining rates;

(6) retain Capitation Payments made by DHHS for Medicaid Eligible Enrollees; and

(7) report to DHHS within 60 calendar days of identifying a Capitation Payment or other payments in excess of the amounts specified in this contract.

Article 2
PAYMENTS

2.1 **Payment Schedule.** DHHS shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the DHHS's 820 report, regardless of whether the Enrollee receives a Covered Service during that month.

2.2 **Capitation Rates.** The Capitation Rates must be actuarially sound. Payment of Capitation rates is based upon the availability of funding. In the event any funding source becomes unavailable, DHHS reserves the right to amend the Capitation Rates to reflect the change in funding and DHHS shall:

(1) notify the Contractor of any change in the Capitation Rates due to a loss of funding; and

(2) make reasonable efforts to notify the Contractor at least 30 calendar days prior to the change in Capitation Rates.

2.3 **Change in Capitation Rates.** If Capitation Rates are changed due to a loss of funding, and the Contractor deems the new rates unacceptable, the Contractor may terminate this contract upon providing DHHS with 60 calendar days written notice of intent to terminate. If the Contractor elects to terminate this contract pursuant to Article 2.2 of this attachment this shall not be considered a default under the contract.

2.4 **Capitation Rates – Legacy Medicaid Population.** DHHS shall pay the Contractor:

Capitation Rates Effective July 1, 2026

Rate Cell	Description	Capitation Rate
A	0-5 Years	$8.93
B	6-18 and 19-20 Independent Living	$74.24
C	Adults (19 - 64 years)	$112.07
D	Aged (65 years and older)	$41.27
F	Disabled, including Blind - Male (All)	$224.86
G	Disabled, including Blind - Female (All)	$223.53
H	Pregnant Women (All)	$56.93
I	Medically Needy Child (0 - 18 years)	$109.31
J	Medically Needy Adult (age 19 and older)	$361.1
K	Foster Care (Inpatient Premiums Only)	$44.55

2.5 **Capitation Rates – Adult Expansion.** DHHS shall pay Capitation Rates listed in the table below for Adult Expansion Enrollees:

Capitation Rates Effective July 1, 2026

Rate Cell	Description	Capitation Rate
N	Parent Male (19-34 years)	$106.22
O	Parent Male (35-64 years)	$36.11
S	Parent Female (19-34 years)	$112.53

T	Parent Female (35-64 years)	$63.24
U	Non-Parent Male (19-34 years)	$123.81
V	Non-Parent Male (35-64 years)	$131.16
W	Non-Parent Female (19-34 years)	$170.31
X	Non-Parent Female (35-64 years)	$130.24

2.6 **Payment Procedures and Reports.** DHHS shall:

(1) make payments to the Contractor through its Provider Reimbursement Information System for Medicaid (PRISM) for all Enrollees under this contract;

(2) shall pay the Contractor the Capitation Rates designated in Article 2.4 and Article 2.5 of this attachment for all current Enrollees listed in the DHHS's 820 report, unless a sanction provision found in Attachment B applies; and

(3) provide, on a weekly basis, an 820 report that includes identifying information on all Enrollees for which DHHS has paid a Capitation Rate and contains summary aggregate information of the count of Enrollees by month and Capitation Rate Cell.

2.7 **Payment Adjustments.** If the Contractor believes an error in Capitation Payment has been made by DHHS, the Contractor shall notify DHHS in writing within 60 calendar days. The Contractor shall supply supporting documentation for DHHS review. If appropriate, DHHS shall adjust the Contractor's Capitation Payment.

2.8 **Automatic Adjustments of Capitation Rates.** DHHS shall automatically adjust Capitation Rates when an Enrollee's aid category is changed retroactively. DHHS shall transmit this information to the Contractor via the Eligibility Transmission.

Article 3

RISK CORRIDOR - Adult Expansion Population

3.1 **Risk Corridor Detail for Adult Expansion.** DHHS shall calculate an adjusted MLR from the MLR specified in Article 20.21 of Attachment B with the following adjustments:

(1) State Directed Payments will be removed from both the numerator and denominator;

(2) any credibility adjustment will be deducted; and

(3) the adjusted MLR is not presumed to meet or exceed the MLR calculation standards if it is non-credible.

3.2 **Basis for Establishment of a Risk Corridor - Adult Expansion.** 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 DHHS 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 DHHS until the adjusted MLR equals 85%.

3.3 **Cost Settlement - Adult Expansion.** DHHS 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 DHHS.

3.4 **Contractor Reimbursement - Adult Expansion.** If the Contractor is required to reimburse DHHS:

(1) the payment shall be in the form of a check; and

(2) failure to make payment to DHHS in full, within 30 calendar days of notification by DHHS, may result in future Capitation Payments being withheld until the payment is received in full.

3.5 **DHHS Reimbursement - Adult Expansion.** If DHHS is required to make payment to the Contractor, DHHS shall make payment through a supplemental payment in a timely manner.

Article 4

RISK CORRIDOR - HUNTSMAN MENTAL HEALTH INSTITUTE (HMHI)

4.1 **Risk Corridor Detail - Huntsman Mental Health Institute (HMHI).** If DHHS receives authorization from CMS to make State Directed Payments to HMHI for inpatient hospital psychiatric services, DHHS shall establish a Risk Corridor around the costs associated with the State Directed Payment described in Attachment B, and the following applies:

(1) The annual rate certification dictates for the Contractor and enrolled population an assumed per member per month (PMPM) amount included to fund the State Directed Payment enhancement;

(2) A benchmark amount shall be computed equal to the assumed HMHI enhancement PMPM documented in the annual PMHP rate certification multiplied by the SFY's Medicaid Member months for the Contractor and the Contractor's rate cells;

(3) A measurement amount shall be computed as the total dollar difference between the assumed standard HMHI Daily rate and the enhanced daily rate, multiplied by actual HMHI utilization during the SFY for the Contractor and the Contractor's rate cells;

(4) The amounts in (2) and (3) shall be aggregated for the Contractor's Legacy Medicaid Population, and the Adult Expansion Enrollees if the Contractor covers Adult Expansion; and

(5) A settlement shall be computed for the HMHI Risk Corridor for each MLR period.

4.2 **Establishment of a Risk Corridor - Huntsman Mental Health Institute (HMHI).** DHHS shall establish a Risk Corridor based on the following threshold amount compared to the ratio of the benchmark and measurement amounts:

(1) A ratio above 102% shall result in payment from DHHS to the Contractor until the ratio equals 102%;

(2) A ratio between 98% and 102% shall result in no action; and

(3) A ratio less than 98% shall result in the Contractor reimbursing DHHS until the adjusted MLR equals 98%.

4.3 **Risk Corridor Determination - Huntsman Mental Health Institute (HMHI).** DHHS shall complete the Risk Corridor determination within 90 calendar days after the Contractor's MLR report is finalized by the auditing contractor.

4.4 **Contractor Reimbursement- Huntsman Mental Health Institute (HMHI).** If the Contractor is required to reimburse DHHS:

(1) the Contractor's payment shall be in the form of a check; and

(2) failure to make payment to DHHS in full, within 30 calendar days of notification by DHHS, may result in future Capitation Payments being withheld until the payment is received in full.

4.5 **DHHS Reimbursement - Huntsman Mental Health Institute (HMHI).** If DHHS is required to make payment to the Contractor, DHHS shall make payment through a supplemental payment in a timely manner.

Article 5
RULES FOR IMDs

5.1 **Capitation Payments for Enrollees in an IMD.** Unless Utah's Medicaid Reform 1115 Demonstration IMD provisions in Article 5.3 of this attachment apply, in accordance with 42 CFR § 438.6(e), DHHS may make a monthly Capitation Payment to the Contractor for an Enrollee age 21 through 64 receiving treatment in an IMD as long as:

(1) the facility is a hospital providing psychiatric inpatient care or the facility is a residential treatment program providing psychiatric or substance use disorder crisis residential services; and

(2) the length of stay in the IMD is for a short-term stay of no more than 15 calendar days during the period of the monthly Capitation Payment.

5.2 **IMD Stays Exceeding 15 Calendar Days.** If the Contractor has authorized a stay in a hospital providing psychiatric inpatient care or in a residential treatment program providing psychiatric or substance use disorder crisis residential services, and the stay exceeds 15 calendar days, the Contractor may be responsible to reimburse the facility. However, if the stay exceeds 15 calendar days, the entire Encounter will not be used for Capitation Rate setting.

5.3 **Requirements under Utah's Medicaid Reform 1115 Demonstration.** In accordance with Utah's Medicaid Reform 1115 Demonstration, the Contractor shall comply with the following requirements for reimbursing facilities that are IMDs:

(1) For Enrollees ages 21 through 64, the Contractor may pay facilities that are IMDs for up to 60 consecutive days per admission. The IMD facilities are:

(A) licensed and Medicare-certified psychiatric hospitals that are IMDs; and

(B) licensed mental health residential treatment programs that are IMDs that are accredited by a nationally recognized accreditation organization;

(2) If the Contractor has authorized a stay in a facility listed in Article 5.3(A)(1) of this attachment or Article 5.3(B)(1) of this attachment, and the stay exceeds 60 calendar days, the Contractor may be responsible to reimburse the facility. However, if the stay exceeds 60 calendar days, the entire Encounter will not be used for Capitation Rate setting; and

(3) The Contractor may reimburse licensed substance use disorder residential treatment programs that are IMDs for Enrollees age 12 or older. There is no limit on the number of days per admission.