

Utah Medicaid
HOME Program
Contract

Healthy Outcomes Medical
Excellence (HOME)

Effective: July 1, 2021 (SFY 2022)

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**Attachment A: UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS
UNIVERSITY OF UTAH, OFFICE OF SPONSORED PROJECTS**

1. DEFINITIONS

- a. "Authorized Persons" means Contractor's employees, officers, partners, Subcontractors or other agents of Contractor who need to access State Data to enable Contractor to perform its responsibilities under the Contract.
- b. "Contract" means this agreement between the Department and Contractor, including the Contract Signature Page(s) and all referenced attachments and documents incorporated by reference.
- c. "Contract Signature Page(s)" means the cover page(s) the Department and Contractor sign.
- d. "Contractor" means the person who delivers the services or goods described in the Contract.
- e. "Department" means the Utah Department of Health.
- f. "Director" means the Executive Director of the Department or authorized representative.
- g. "Goods" means any deliverable that is not defined as a Service that Contractor is required to deliver under the Contract.
- h. "Originating funding entity" means an individual or entity which provided to the Department any or all funds payable under this Contract.
- i. "Person" means any governmental entity, business, individual, union, committee, club, other organization, or group of individuals.
- j. "Services" means the furnishing of labor, time, or effort by Contractor pursuant to this Contract. Services include, but are not limited to, all of the deliverable(s) (including supplies, equipment, or commodities) that result from Contractor performing the Services pursuant to this Contract. Services include those professional services identified in Section 63G-6a-103 of the Utah Procurement Code.
- k. "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.
- l. "State Data" means all confidential information, non-public data, personal data, and protected health information that is created or in any way originating with the State whether such data or output is stored on the Department's hardware, Contractor's hardware, or exists in any system owned, maintained or otherwise controlled by the Department or by the Contractor. State Data includes any federal data that the Department controls or maintains, that is protected under federal laws, statutes, and regulations. The Department reserves the right to identify, during and after the Contract, additional reasonable types of categories of information that must be kept confidential under federal and state laws.
- m. "State money" means money that is owned, held or administered by a state agency and

derived from state fee or tax revenues but does not include contributions or donations received by the state agency.

- n. "Subaward" means an award provided by the Contractor to a subrecipient for the subrecipient to carry out part of a Federal award passed through to the Contractor.
 - o. "Subcontract" means a written agreement between Contractor and another party to fulfill the requirements of the Contract.
 - p. "Subcontractor" means subcontractors or subconsultants at any tier that are under the direct or indirect control or responsibility of the Contractor, and includes all independent contractors, agents, employees, authorized resellers, or anyone else for whom the Contractor may be liable at any tier, including a person or entity that is, or will be, providing or performing an essential aspect of this Contract, including Contractor's manufacturers, distributors, and suppliers.
 - q. "Subrecipient" means a non-Federal entity that receives a subaward from the Contractor to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program.
 - r. "Uniform Guidance" means Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards for the specified federal awarding agency set forth in Title 2 of the Code of Federal Regulations.
2. **EFFECTIVE DATE:** Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in the Contract.
 3. **GOVERNING LAW AND VENUE:** This Contract shall be governed by the laws, rules, and regulations of the State of Utah. Any action or proceeding arising from the Contract shall be brought in a court of competent jurisdiction in the State of Utah. Venue shall be in Salt Lake City, in the Third Judicial District Court for Salt Lake County.
 4. **AMENDMENTS:** The Contract may only be amended by mutual written agreement signed by both parties, which amendment will be attached to the Contract. Automatic renewals will not apply to the Contract, even if listed elsewhere in the Contract.
 5. **CHANGES IN SCOPE:** Any changes in the scope of the Services to be performed under this Contract shall be in the form of a written amendment to this Contract, mutually agreed to and signed by both parties, specifying any such changes, fee adjustments, any adjustment in time of performance, or any other significant factors arising from the changes in the scope of Services.
 6. **LAWS AND REGULATIONS:** At all times during the Contract, Contractor shall comply with all applicable federal and state constitutions, laws, rules, codes, orders, and regulations, including licensure and certification requirements. If the Contract is funded by federal funds, either in whole or in part, then any federal regulation related to the federal funding will supersede this Attachment A.
 7. **INDEPENDENT CONTRACTORS:** Contractor shall ensure that any non-state government Subcontractors shall act in an independent capacity and not as officers or employees or agents of the Department or State.

- 8. PROCUREMENT ETHICS:** Contractor understands that a person who is interested in any way in the sale of any supplies, services, construction, or insurance to the State of Utah is violating the law if the person gives or offers to give any compensation, gratuity, contribution, loan, reward, or any promise thereof to any person acting as a procurement officer on behalf of the State of Utah, or who in any official capacity participates in the procurement of such supplies, services, construction, or insurance, whether it is given for their own use or for the use or benefit of any other person or organization.
- 9. INVOICING:** Unless otherwise stated in the Special Provisions of the Contract, Contractor will submit invoices along with any supporting documentation within thirty (30) days following the last day of the month in which the expenditures were incurred or the services provided or within thirty (30) days of the delivery of the Good to the Department. The contract number shall be listed on all invoices, freight tickets, and correspondence relating to this Contract. The prices paid by the Department will be those prices listed in this Contract, unless Contractor offers a prompt payment discount on its invoice. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

10. PAYMENT:

- 10.1.** The Department shall reimburse total actual expenditures, less amounts collected by Contractor from any other person not a party to the Contract legally liable for the payments for the goods and services.
- 10.2.** The Department shall make payments within thirty (30) days after a correct invoice is received.
- 10.3.** By signing the Contract, Contractor acknowledges that the Department cannot contract for the payment of funds not yet appropriated by the Utah State Legislature or received from federal sources. If funding to the Department is reduced due to an order by the Legislature or the governor, or is required by state law, or if applicable federal funding is not provided to the Department, the Department shall reimburse Contractor for products delivered and services performed through the date of cancellation or reduction, and the Department shall not be liable for any future commitments, penalties, or liquidated damages.
- 10.4.** Upon 30 days written notice, Contractor shall reimburse Department for funds the Department is required to reimburse the grantor or originating funding entity up to the amount repaid resulting from the actions of the Contractor or its Subcontractors provided, however, that such reimbursement amount shall in no event exceed the amount of funds received by Contractor pursuant to this Contract. The foregoing limitation on reimbursable amounts shall not apply to any fine, penalty, or sanction imposed against the Department by the original grantor of any federal funds, to the extent such fine, penalty, or sanction is based on the acts or omissions of Contractor.

- 11. NONAPPROPRIATION OF FUNDS, REDUCTION OF FUNDS, OR CHANGES IN LAW:** Upon thirty (30) days written notice delivered to the Contractor, this Contract may be terminated in whole or in part at the sole discretion of the Department, if the Department reasonably determines that: (i) a change in Federal or State legislation or applicable laws materially affects the ability of either party to perform under the terms of this Contract; or (ii) that a change in available funds affects the Department's ability to pay under this

Contract. A change of available funds as used in this paragraph includes, but is not limited to, a change in Federal or State funding, whether as a result of a legislative act or by order of the President or the Governor.

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

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

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

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

15. TERMINATION AND DEFAULT:

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

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

15.3. Each party may terminate the Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of the Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within thirty (30) days of the notice. If the default is not cured within the thirty (30) days, the party giving notice may terminate the Contract forty (40) days from the date of the initial notice of default or at a later date specified in the notice.

- 15.4.** Upon termination of the Contract, all accounts and payments for services rendered to the date of termination shall be processed according to the financial arrangements set forth herein for approved services rendered to date of termination. If the Department terminates the Contract, Contractor shall stop all work as specified in the notice of termination. The Department shall not be liable for work or services performed beyond the termination date as specified in the notice of termination.
- 15.5.** In the event of such termination, Contractor shall be compensated for services properly performed under the Contract up to the effective date of the notice of termination. Contractor agrees that in the event of such termination for cause or without cause, Contractor's sole remedy and monetary recovery from the State is limited to full payment for all work properly performed as authorized under the Contract up to the date of termination as well as any reasonable monies owed as a result of Contractor having to terminate contracts necessarily and appropriately entered into by Contractor pursuant to the Contract.
- 15.6.** If the Department terminates the Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace Contractor's obligations. If the termination is due to Contractor's failure to perform, and the Department procures replacement goods or services, Contractor agrees to pay the reasonable costs associated with obtaining the replacement goods or services.
- 15.7.** If Contractor terminates the Contract without cause, the Department may treat Contractor's action as a default under the Contract.
- 15.8.** If Contractor materially defaults in any manner in the performance of any obligation under the Contract, or if audit exceptions are identified, the Department may, at its option, to the extent a payment (or portion thereof) corresponds to the default, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. Default and audit exceptions for which payment may be adjusted or withheld include disallowed expenditures of federal or state funds as a result of Contractor's failure to comply with federal regulations or state rules. In addition, the Department may withhold amounts due Contractor under the Contract, or any future payments due Contractor to recover the funds under this Contract. The Department shall notify Contractor of the Department's action in adjusting the amount of payment or withholding payment. The Contract is executory until such repayment is made.
- 15.9.** Any of the following events will constitute cause for the Department to declare Contractor in default of this Contract: (i) Contractor's non-performance of its contractual requirements and obligations under this Contract; or (ii) Contractor's material breach of any term or condition of this Contract. Time allowed for cure will not diminish or eliminate Contractor's liability for damages. If the default remains after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: (i) exercise any remedy provided by law or equity; (ii) terminate this Contract; or (iii) debar/suspend Contractor from receiving future contracts from the Department or the State of Utah; or (v) demand a full refund of any payment that the Department has made to Contractor under this Contract for Goods that do not conform to this Contract.

- 15.10.** The rights and remedies of the Department enumerated in this article are in addition to any other rights or remedies provided in the Contract or available in law or equity.
- 16. REVIEWS:** The Department reserves the right to perform plan checks, plan reviews, other reviews, and/or comment upon the Goods and Services of Contractor. Such reviews do not waive the requirement of Contractor to meet all of the terms and conditions of the Contract.
- 17. PERFORMANCE EVALUATION:** The Department may conduct a performance evaluation of Contractor's Services, including Contractor's Subcontractors. Results of any evaluation may be made available to Contractor upon request. Such reviews shall be performed in a manner that will cause minimal disruption to Contractor's operations.
- 18. PUBLIC INFORMATION:** Each party agrees that the Contract, related purchase orders, related pricing documents, and invoices will be public documents and may be available for public and private distribution in accordance with the State of Utah's Government Records Access and Management Act (GRAMA).
- 19. PUBLICITY:** Contractor shall submit to the Department for written approval all advertising and publicity matters relating to this Contract. It is within the Department's sole discretion whether to provide approval, which must be done in writing.
- 20. 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 Contractor shall ensure it maintains exclusive ownership and title to all information gathered, reports developed, and conclusions reached in performance of the Contract. Subcontractor shall not use or disclose information gathered, reports developed, or conclusions reached in performance of activities arising out of this Contract without prior written consent from the Contractor.
- 21. INFORMATION PRACTICES:** Contractor shall establish, maintain, and practice information procedures and controls that comply with federal and state law including, as applicable, Utah Code § 26-1-1 *et seq.* and the privacy and security standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") & the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"). Contractor shall receive or request from the Department only information about an individual that is necessary to Contractor's performance of its duties and functions. Contractor shall use the information only for purposes of the Contract. The Department shall inform Contractor of any non-public designation of any information it provides to Contractor.
- 22. SECURE PROTECTION AND HANDLING OF STATE DATA:**
- 22.1.** If Contractor is given State Data as part of this Contract, the protection of State Data shall be an integral part of the business activities of Contractor to ensure that there is no inappropriate or unauthorized use of State Data. To the extent that Contractor is given State Data, Contractor shall safeguard the confidentiality, integrity, and availability of the State Data. Contractor agrees to not copy, reproduce, sell, assign, license, market, transfer, or otherwise dispose of, give, or disclose such information to third parties or use such information for any purpose whatsoever other than the performance of the Contract. The improper use or disclosure of confidential information is strictly prohibited.

- 22.2.** Any and all transmission or exchange of State Data shall take place via secure means. Contractor shall create, store, and maintain any State Data on secure or encrypted computing devices or any portable storage mediums. Contractor agrees to protect and maintain the security of State Data with security measures including, but are not limited to, maintaining secure environments that are patched and up to date with all appropriate security updates as designated, network firewall provisioning, and intrusion detection. Contractor agrees that any computing device or portable medium that has access to the Department's network or stores any non-public State Data is equipped with strong and secure password protection.
- 22.3.** Contractor shall: (a) limit disclosure of any State Data to Authorized Person who have a need to know such information in connection with the current or contemplated business relationship between the parties to which the Contract relates, and only for that purpose; (b) advise its Authorized Persons of the proprietary nature of the State Data and of the obligations set forth in the Contract and require such Authorized Persons to keep the State Data confidential; (c) keep all State Data strictly confidential by using a reasonable degree of care, but not less than the degree of care used by it in safeguarding its own confidential information; and (d) not disclose any State Data received by it to any third parties, except as permitted by the Contract or otherwise agreed to in writing by the Department.
- 22.4.** Contractor will promptly notify the Department of any misuse or misappropriation of State Data that comes to Contractor's attention. Contractor shall be responsible for any breach of this duty of confidentiality by any of their officers, agents, subcontractors at any tier, and any of their respective representatives, including any required remedies and/or notifications under applicable law (Utah Code Ann. §§ 13-44-101 through 301). This duty of confidentiality shall be ongoing and survive the term of the Contract. Notwithstanding the foregoing, if there is a discrepancy between a signed business associate agreement and this provision, the business associate agreement language shall take precedence.

23. OWNERSHIP IN INTELLECTUAL PROPERTY: The Department and Contractor agree that each has no right, title, interest, proprietary or otherwise in the intellectual property owned or licensed by the other, unless otherwise agreed upon by the parties in writing. Unless otherwise specified in the Special Provisions, with respect to Services that constitute sponsored research, subject to applicable rights retained by or granted to the federal government for Services funded by Federal Pass Through Money, Contractor shall own all right, title and interest in all inventions and improvements conceived or reduced to practice by Contractor or Contractor personnel in the performance of this Contract (hereinafter collectively "Invention") and may, at its election, file all patent applications relating thereto. In consideration of Department's support of Contractor in performance of such Services and subject to receipt of compensation as provided for under this Contract, Contractor hereby grants Department a nonexclusive, nontransferable, irrevocable, paid-up license to practice, or have practiced for or on its behalf, Inventions throughout the world. With respect to all other Services, all deliverables, documents, records, programs, data, articles, memoranda, and other materials not developed or licensed by Contractor prior to the execution of this Contract, but specifically created or manufactured exclusively with funds or proceeds under this Contract shall be considered work made for hire, and Contractor shall transfer any

ownership claim to the Department.

- 24. SOFTWARE OWNERSHIP:** If Contractor develops or pays to have developed computer software exclusively with funds or proceeds from the Contract to (i) perform its obligations under the Contract, or (ii) to perform computerized tasks that it was not previously performing to meet its obligations under the Contract, the computer software shall be licensed to the Department. If Contractor develops or pays to have developed computer software exclusively with funds or proceeds from the Contract (i) which is an addition to existing software owned by Contractor, or (ii) to modify software owned by Contractor to perform computerized tasks in a manner different than previously performed specifically, to meet its obligations under the Contract, the addition (but not the underlying software) shall be licensed to the Department. In the case of software owned by the Department, the Department grants to Contractor a nontransferable, nonexclusive license to use the software in the performance of the Contract. In the case of software licensed to the Department, the Department grants to Contractor permission to use the software in the performance of the Contract. This license or permission, as the case may be, terminates when Contractor has completed its work under the Contract. If Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by the Contract, then to the extent allowed by the license agreement between Contractor and the owner of the software, Contractor grants to the Department a continuing, nonexclusive license for either the Department or a different contractor to use the software in order to perform work substantially identical to the work performed by Contractor under the Contract. If Contractor cannot grant the license as required by this section, then Contractor shall reveal the input screens, report formats, data structures, linkages, and relations used in performing its obligations under the contract in such a manner to allow the Department or another contractor to continue the work performed by contractor under the Contract.
- 25. UPDATES AND UPGRADES:** Contractor grants to the Department a non-exclusive, non-transferable license to use upgrades and updates provided by Contractor during the term of the Contract. Such upgrades and updates are subject to the terms of the Contract. The Department shall download, distribute, and install all updates as released by Contractor during the length of the Contract, and Contractor strongly suggests that the Department also downloads, distributes, and installs all upgrades as released by Contractor during the length of the Contract. Contractor shall use commercially reasonable efforts to provide the Department with work-around solutions or patches to reported software problems that may affect the Department's use of the software during the length of the Contract.
- 26. TECHNICAL SUPPORT AND MAINTENANCE:** If technical support and maintenance is a part of the Goods that Contractor provides under the Contract, Contractor will use commercially reasonable efforts to respond to the Department in a reasonable time when the Department makes technical support or maintenance requests regarding the Goods.
- 27. EQUIPMENT PURCHASE:** Contractor shall obtain prior written Department approval before purchasing any equipment, as defined in the Uniform Guidance, with Contract funds.
- 28. ACCEPTANCE AND REJECTION:** The Department shall have thirty (30) days after the performance of the Services to perform an inspection of the Services to determine whether the Services conform to the standards specified in the Solicitation and this Contract prior to acceptance of the Services by the Department. If Contractor delivers nonconforming Services,

the Department may, at its option and at Contractor's expense: (i) return the Services for a full refund; (ii) require Contractor to promptly correct or re-perform the nonconforming Services subject to the terms of this Contract; or (iii) obtain replacement Services from another source, subject to Contractor being responsible for any cover costs.

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

30. RECORD KEEPING, AUDITS, & INSPECTIONS:

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

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

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

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

31. EMPLOYMENT PRACTICES: Contractor shall abide by the following employment laws, as applicable: (i) Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e) which prohibits discrimination against any employee or applicant for employment or any applicant or recipient of services, on the basis of race, religion, color, or national origin; (ii) Executive Order No. 11246, as amended, which prohibits discrimination on the basis of sex; (iii) 45 C.F.R. § 90 which prohibits discrimination on the basis of age; (iv) Section 504 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act of 1990, which prohibits discrimination on the basis of disabilities; (v) Utah Executive Order No. 2006-0012, dated December 13, 2006, which prohibits unlawful harassment in the work place; (vi) Utah Code Ann. § 26-38-1 *et. seq.*, Utah Indoor Clean Air Act which prohibits smoking in enclosed public places; (vii) Utah Executive Order No. 2006-0012 which prohibits all unlawful harassment in any workplace in which state employees and employees of public and higher education must conduct business; (viii) 41 CFR part 60, Equal Employment Opportunity, and the Executive Order 11246, as amended by Executive

Order 11375, which implements those regulations; (ix) 45 C.F.R. part 83, which prohibits the extension of federal support to any entity that discriminates on the basis of sex in the admission of individuals to its health manpower and nurse training programs; and (x) 40 U.S.C. §§ 3702 and 3704, as supplemented by Department of Labor regulations (29 C.F.R. part 5), Contract Work Hours and Safety Standards Act, for contracts that involve the employment of mechanics or laborers. Contractor further agrees to abide by any other laws, regulations, or orders that prohibit the discrimination of any kind of any of Contractor's employees.

- 32. FEDERAL REQUIREMENTS:** Contractor shall abide by the following federal statutes, regulations and requirements, including, but not limited to (i) 2 C.F.R. § 200.326, Contract Provisions as applicable; (ii) 45 C.F.R. § 46, Protection of Human Subject in research activities; (iii) 45 C.F.R. part 84, prohibits discrimination of drug or alcohol abusers or alcoholics who are suffering from mental conditions from admission or treatment by any private or public hospital or outpatient facility that receives support or benefit from a federally funded program; (iv) 42 C.F.R. parts 2 and 2a which implements the Public Health Service Act, sections 301(d) and 543, which requires certain medical records that relate to drug abuse prevention be kept confidential when the treatment or program is directly or indirectly assisted by the federal government; (v) 42 U.S.C. §§ 7401-7971q., the Clean Air Act and 33 U.S.C. §§ 1251-1387, the Federal Water Pollution Control Act, and all applicable standards, orders or related regulations; (vi) 31 U.S.C. § 1352, Byrd Anti-Lobbying Amendment; (vii) 42 U.S.C § 4331, the National Environmental Policy Act of 1969; (viii) 2 C.F.R. § 200.322, Procurement of recovered materials which outlines section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act; (ix) 37 C.F.R. § 401, Rights to Inventions Made; (x) 42 C.F.R. part 50, Subpart B, Sterilizations; (xi) 42 C.F.R. part 50, Subpart C, Abortions and Related Medical Services; (xii) 59 FR 46266, Recombinant DNA and Institutional Biosafety; (xiii) 7 U.S.C. § 2131, Animal Welfare; (xiv) 42 C.F.R. part 92, Misconduct in Science; (xv) 42 U.S.C. §§ 4728-4763, Merit System Standards for governmental entities only; and (xvi) Contractor shall include in any contracts termination clauses for cause and convenience, along with administrative, contractual, or legal remedies in instances where subcontractors violate or breach contract terms and provides for such sanctions and penalties as may be appropriate.
- 33. WAIVER:** A waiver of any right, power, or privilege shall not be construed as a waiver of any subsequent right, power, or privilege.
- 34. SUBCONTRACTS & ASSIGNMENT:** Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of the Contract that are subcontracted or performed by a Subcontractor. When subcontracting, Contractor agrees to use written subcontracts that conform to federal and state laws. If Subcontractor is a Subrecipient as defined by this contract, **Contractor shall comply with all federal regulations governing Subrecipients as set out in 2 C.F.R. Part 200.** If Contractor enters into an agreement with a Subrecipient, Contractor shall notify the Department of its compliance with 2 C.F.R. Part 200 in the manner required by the Department.
- 35. FORCE MAJEURE:** Neither party shall be held responsible for delay or default caused by fire, riot, acts of God, or war which is beyond the party's reasonable control. The Department may terminate the Contract after determining that the delay or default will likely prevent successful performance of the Contract.

Attachment B – Special Provisions

Article 1: Introductory Provisions

1.1 Parties

(A) This Contract is between the State of Utah, acting by and through its Department of Health hereinafter referred to as “Department” and Healthy Outcomes, Medical Excellence (HOME), hereinafter referred to as “Contractor.” Together, the Department and Contractor shall be referred to as the “Parties.”

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

1.2 Notices

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

- (a) certified or registered United States mail, return receipt requested;
- (b) personal delivery; or
- (c) expedited delivery service.

Such notices shall be addressed as follows:

Department (if by mail):

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

Department (if in person):

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

Contractor:

Healthy Outcomes, Medical Excellence (HOME)
240 E Morris Ave., #400
Salt Lake City, UT 84115

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

1.3 Service Area

1.3.1 Service Area, Generally

(A) The Service Area is the specific geographic area within which the Medicaid Eligible Individual must reside to enroll in the Contractor's Health Plan. The Service Area for this Contract is in the following counties: Salt Lake, Utah, Weber, Davis, Tooele, Summit and Wasatch.

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

1.3.2 Reduction of Service Area

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

1.3.3 Service Area Expansion

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

1.3.4 Residency in Service Area

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

1.3.5 Mandatory/Voluntary Enrollment Service Areas

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

Article 2: Definitions

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

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

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

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

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

Adult Expansion Population means the eligible membership limited to parents and adults without dependent children, earning up to 138% of the federal poverty level.

Adverse Benefit Determination means:

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

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

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

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

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

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

Benefit Issuance Date means the monthly date that the eREP system determines eligibility and the Medicaid Managed Care System (MMCS) issues premiums to Health Plans.

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

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

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

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

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

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

- (1) is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act);
- (2) is in Foster Care or other out-of-home placement;
- (3) is receiving Foster Care or adoption assistance; or
- (4) is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in Section 501(a)(1)(D) of Title V of the Social Security Act.

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

Claim includes:

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

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

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

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

- (1) outpatient hospital services;
- (2) rural health clinic services;
- (3) Federally Qualified Health Center (FQHC) services;
- (4) other laboratory and X-ray services;
- (5) Nursing facility (NF) services;

- (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services;
- (7) family planning services;
- (8) physician services; and
- (9) home health services.

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

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

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

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

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

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

Date of Discovery means the identification of an Overpayment by any governmental entity, Provider, or Contractor and the date on which communication of that Overpayment finding or the initiation of a formal recoupment action without notice as described in 42 CFR 433.316.

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

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

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

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

Eligibility Transmission means the 834 Benefit Enrollment and Maintenance File.

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

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

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

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

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

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

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

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

Exclusion or Excluded means the temporary or permanent barring of a person or other entity from participation in the Medicare or Medicaid program and that services furnished or ordered by that person are not paid for under either program.

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

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

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

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

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

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

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

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

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

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

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

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

Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. 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 process the Contractor implements to handle Appeals of an Adverse Benefit Determination, Grievances, as well as the process to collect and track information about them.

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

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

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

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

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

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 Part 441, Subpart G. These services cover an array of Home and Community-Based Services that are cost-effective and necessary for an individual to avoid institutionalization.

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

Indian means an individual, as defined by 25 U.S.C. 1603(13), 1603(28), or 1679(a) or who has been determined eligible, as in Indian, under 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers.

Indian Health Care Provider (IHCP) means a health care program, operated by Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

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

Integrated Care Plan (ICP) means one of the Utah Medicaid Integrated Care MCOs.

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

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

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

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

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

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

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a Comprehensive Risk Contract, and that is – (1) A Federally qualified HMO that meets the Advance Directives requirements of 42 CFR 489, Subpart I; or (2) Any public or private entity that meets the Advance Directives requirement of 42 CFR 489, Subpart I and is determined by

the Secretary of the U.S. Department of Health and Human Services to also meet the following conditions: (i) Makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served by the entity and (ii) meets the solvency standards of 42 CFR 438.116.

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

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

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

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

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

Medicaid Fee Schedule means a listing of fees that Utah Medicaid reimburses Medicaid providers who bill Medicaid. For the procedures that are listed in the Medicaid Fee Schedule, generally, Utah Medicaid reimburses providers the lesser of their billed amount and the amount listed in the Medicaid Fee Schedule.

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

Medicaid Information Bulletins (MIB) means an official, periodic publication of the Division of Medicaid and Health Financing to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Medical Institution means a facility designed primarily to provide medical care. Medical Institutions include, but are not limited to: Hospitals, SNFs, ICFs, The Utah State Developmental Center, and IMDs.

Medical Loss Ratio (MLR) means a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs.

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

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

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

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

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

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

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

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

National Quality Forum (NQF) means a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare.

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

Office of Health Care Statistics (OHCS) means the Utah Department of Health office responsible for collecting, analyzing and disseminating health care data.

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

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

Overpayment Discovery Date means the date the Contractor issues to a Provider a formal notice of recovery of an alleged Overpayment related to Fraud, Waste, or Abuse.

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

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

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

- (1) has an ownership interest totaling 5 percent or more in the Contractor;
- (2) has an indirect ownership interest equal to 5 percent or more in the Contractor;
- (3) has a combination of direct and indirect ownership interests equal to 5 percent or more in the Contractor;
- (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the property or assets of the Contractor;
- (5) is an officer or director of the Contractor including the Contractor's Board of Directors' members, if applicable; or
- (6) is a partner in the Contractor that is organized as a partnership.

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

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

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

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

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

Prepaid Mental Health Plan (PMHP) means the Medicaid mental health and substance use disorder managed care plan that covers inpatient and outpatient mental health services and outpatient substance use disorder services.

Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician,

obstetrician/gynecologist, pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

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

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

Prior Authorization see Service Authorization Request.

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

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

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

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

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

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

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 Overpayment Discovery Date, or longer if the Contractor is actively collecting the Overpayment from the Provider.

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

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

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

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

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

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

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

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

State Health Care Program means:

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

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

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

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

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

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

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

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

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

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

Waste means overutilization of resources or inappropriate payment.

Article 3: Marketing and Enrollment

3.1 Marketing Activities

3.1.1 Marketing, Generally

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

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

3.1.2 Prohibited Marketing Activities

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

- (1) directly or indirectly, conducting door-to-door, telephonic, or other Cold-Call Marketing activities;
- (2) influencing a Potential Enrollee's enrollment in conjunction with the sale or offering of any private insurance; and
- (3) distributing any materials that include statements that will be considered inaccurate, false, or misleading. Such statements can include that the Potential Enrollee must enroll with the Contractor in order to obtain or not to lose benefits; or that the Contractor has been endorsed by CMS, the Federal or State government, or similar entity.

3.1.3 Permitted Marketing Activities

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

- (1) the Contractor operates a Qualified Health Plan (QHP) on the Federally Facilitated Marketplace;
- (2) the marketing will only be distributed to persons currently enrolled on the QHP's marketplace product or to persons who are actively seeking enrollment in the QHP's marketplace product;
- (3) the Marketing Activities will be limited to print materials and discussions directly with the person. Broad Marketing Activities via media or through public displays are not permitted; and
- (4) the purpose of the Marketing Materials is to create continuity for families who may wish to receive services for all Family Members with one plan. In addition, Marketing Materials will help Enrollees transitioning to or from Medicaid to allow continuity of care with their QHP marketplace plan.

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

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

3.2.2 Department Approval

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

3.2.3 Specify Methods

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

3.2.4 Distribution of Marketing Materials

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

3.2.5 Marketing Activities Prohibited

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

3.3 Enrollment Process

3.3.1 Enrollee Choice

(A) The Contractor shall have a continuous open enrollment period for new Enrollees. Enrollment is open to any qualified Medicaid Eligible Individual who meets the eligibility requirements for enrollment. The Department shall certify, and the Contractor agrees to accept, individuals who are eligible to be enrolled in the Health Plan. Contractor shall accept Enrollees in the order in which they apply.

(B) New Enrollees shall be selected based upon the eligibility requirement that the Medicaid Eligible Individual has a development disability that is medically complex with major developmental challenges due to mental illness or behavioral problems.

(C) Enrollees may be made retroactively eligible up to 6 months.

3.3.2 Period of Enrollment

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

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

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

3.3.3 Prohibition Against Conditions on Enrollment

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

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

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

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

3.3.5 Independent Enrollment and Enrollment Process

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

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

3.4 Eligibility Transmission

3.4.1 Eligibility Transmission, Generally

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

(B) The Eligibility Transmission shall be in accordance with the Utah Health Information Network (UHIN) standard. The Contractor shall have the ability to receive and process the Eligibility Transmission.

(C) Critical Fields found in the Eligibility Transmission shall include: Enrollee's case number, case name, eREP identification number, name, date of birth, date of death, social security number, gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, (including those for Indians) eligibility start date, Third Party

Liability coverage, county, address, phone number, and if applicable, the Enrollee's Provider under the Restriction Program when such information is available.

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

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

3.4.2 Eligibility Transmission, Specific Types of Enrollees

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

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

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

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

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

3.4.3 Eligibility File, Contractor Responsibilities

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

(B) The Contractor shall follow the policies and procedures found in the Department's 834 Benefit and Enrollment Companion Guide, the HIPAA X12 Benefit Enrollment and Maintenance (834) Implementation Guide, and any amendments to these documents.

3.5 Member Orientation

3.5.1 Initial Contact—General Orientation

(A) Within 30 days of Enrollment, the Contractor shall conduct an in-person welcome intake visit with the Enrollee. During the welcome intake visit the Contractor shall:

- (1) give specific written and oral instructions on how the Enrollee may obtain Covered Service and the Contractor's procedures for obtaining Covered Services;
- (2) explain that to the Enrollee that his/her primary care services, medication management, and mental health concerns will be provided at the Contractor's Clinic;
- (3) explain the Contractor's case management and care coordination model;
- (4) introduce the Enrollee to his/her assigned case manager;
- (5) provide each Enrollee a HOME Member Handbook, Provider Directory, and HOME staff phone list;
- (6) explain the availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Non-Network Providers;
- (7) explain the Rights and Responsibilities of the Enrollee under the Health Plan, including the right to file a Grievance and how to file a Grievance; and
- (8) explain the right to terminate enrollment with the Health Plan.

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

3.5.2 Initial Contact-- Enrollees with Special Health Care Needs

(A) The Contractor understands and agrees that all of the Contractor's Enrollees are Enrollees with Special Health Care Needs.

(B) The Contractor shall establish a policy which shall be used by Contractor's representative during the initial contact to identify persons who need LTSS, to the extent the LTSS are Covered Services under this Contract.

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

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

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

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

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

3.6 Enrollee Information

3.6.1 Enrollee Information, Generally

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

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

- (1) it is in a format that is Readily Accessible;
- (2) the information is placed on a location in the Contractor's website that is prominent and Readily Accessible;
- (3) the information is in an electronic form which can be electronically retained and printed;
- (4) the information is consistent with content and language requirements; and
- (5) the Contractor notifies the Enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.

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

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

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

(F) The Contractor shall notify its Enrollees that:

- (1) Oral interpretation is available for any language, and how to access those services;
- (2) Written translation is available in prevalent languages, and how to access those services; and
- (3) Auxiliary aids and services are available upon request at no cost for Enrollees with disabilities, and how to access those services.

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

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

(I) The Contractor shall use Enrollee notices developed by the Department.

3.6.2 Enrollee Information Requirements—Prevalent Language

The Contractor shall use the Eligibility Transmissions to determine prevalent non-English languages. A language is prevalent when it is spoken by five percent or more of the Contractor's enrolled population.**3.6.3 All Written Materials**

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

(B) The Contractor shall provide all written materials for Potential Enrollees and Enrollees in alternative formats upon request and at no cost, and in an appropriate manner that takes into

consideration the special needs of Potential Enrollees or Enrollees with disabilities or limited English proficiency.

3.6.4 Written Materials Critical to Obtaining Services

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

(B) The Contractor shall include taglines that:

- (1) are in the prevalent non-English languages in the State;
- (2) are in a conspicuously visible font size;
- (3) explain the availability of written translation or oral interpretation to understand the information provided at no cost;
- (4) provide information on how to request auxiliary aids and services and that they are provided at no cost; and
- (5) include the toll-free and the TTY/TDD telephone numbers of the Contractor's Member Services/customer service unit

3.6.5 Enrollee Handbook

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

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

(C) The Enrollee handbook shall contain information:

- (1) that enables the Enrollee to understand how to effectively use the Contractor's Managed Care Program;
- (2) on benefits provided by the Contractor, including information about the EPSDT benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled with the Contractor;
- (3) on how and where to access any benefits provided by the Department, including any cost sharing, EPSDT benefits delivered outside the Contractor, if any, and how transportation is provided;

- (4) regarding cost sharing on any benefits carved out of the Contract and provided by the Department;
- (5) which details that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall inform Enrollees that the service is not covered by the Contractor and how they can obtain information from the Department about how to access those services;
- (6) on the amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;
- (7) procedures for obtaining benefits, including service authorization requirements and/or referrals for specialty care and for other benefits not furnished by the Enrollee's PCP;
- (8) on the extent to which, and how, after-hours care is provided;
- (9) on how emergency care is provided;
- (10) regarding what constitutes an Emergency Medical Condition;
- (11) regarding what constitutes an Emergency Service;
- (12) that prior authorization is not required for Emergency Services;
- (13) that the Enrollee has the right to use any hospital or other setting for emergency care;
- (14) on cost sharing for services furnished by the Contractor, if any is imposed under the State Plan;
- (15) on the Post-Stabilization Care Services rules set forth at 42 CFR 422.113(c);
- (16) on any restriction on the Enrollee's freedom of choice among Network Providers;
- (17) on the extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from Non-Network Providers;
- (18) that includes an explanation that Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider;
- (19) on Enrollee rights and responsibilities, including the Enrollee's right to:
 - (i) receive information on beneficiary and plan information;
 - (ii) be treated with respect and with due consideration for the Enrollee's dignity and privacy;
 - (iii) receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

- (iv) participate in decisions regarding the Enrollee’s health care, including the right to refuse treatment;
 - (v) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - (vi) request and receive a copy of the Enrollee’s medical records and request that they be amended or corrected; and
 - (vii) obtain available and accessible health care services covered under the Contract.
- (20) on the process of selecting and changing the Enrollee’s PCP;
 - (21) on Grievance, Appeal, and State Fair Hearing procedures and timeframes developed by or described in a manner approved by the Department;
 - (22) on the Enrollee’s right to file Grievances and Appeals;
 - (23) on the requirements and timeframes for filing a Grievance or requesting an Appeal;
 - (24) on the availability of assistance in the filing process for Grievances;
 - (25) on the availability of assistance in the filing process for Appeals;
 - (26) on the Enrollee’s right to request a State Fair Hearing after the Contractor has made a determination on an Enrollee’s appeal which is adverse to the Enrollee;
 - (27) that when requested by the Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the Enrollee may, consistent with state policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee;
 - (28) that Indian Enrollees may obtain Covered Services directly from an Indian Health Care Provider;
 - (29) on how to exercise an Advance Directive;
 - (30) on how to access auxiliary aids and services, including additional information in alternative formats or languages at no cost;
 - (31) regarding the toll-free telephone numbers for member services, medical management, and any other unit providing services directly to Enrollees;
 - (32) on how to report suspected Fraud or Abuse;
 - (33) that describe the transition of care policies for Enrollees and Potential Enrollees; and
 - (34) any other content required by the Department.

3.6.5 Enrollee Handbook Dissemination

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

- (1) mails a printed copy of the information to the Enrollee's mailing address;
- (2) provides the information by email after obtaining the Enrollee's agreement to receive the information by email;
- (3) posts the information on its website and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- (4) provides the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3.6.6 Enrollee Handbook Review and Approval

(A) On or before May 1st of each year, the Contractor shall submit its Enrollee handbook to the Department for review and approval. The handbook shall be submitted to the Department with all changes from the previous handbook tracked. The Department shall notify the Contractor in writing of its approval or disapproval within 30 calendar days after receiving the Enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon timeframe, the Contractor may deem such materials approved by the Department.

(B) If there are changes to the content of the material in the Enrollee handbook, the Contractor shall update the Enrollee handbook and submit a draft with tracked changes to the Department for review and approval 45 working days before distribution to Enrollees. The Department shall notify the Contractor in writing of its approval or disapproval within 30 working days after receiving the Enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon timeframe, the Contractor may deem such materials approved by the Department.

3.6.7 Enrollee Notice of Significant Change

(A) After the Department has approved the Contractor's model Enrollee handbook, if the Contractor intends to make any change to its Enrollee handbook, including changes that would impact the information specified in Article 3.6.4 (C):

- (1) the Contractor shall notify the Department in writing within 60 calendar days of the intended effective date of the change; and
- (2) the Department shall, within 10 working days of the notification, determine if the change is significant and inform the Contractor of its decision.

(B) If the Department identifies a significant change that would impact the information specified in Article 3.5.4 (C), the Department shall notify the Contractor in writing within 60 calendar days of the intended effective date of the change.

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

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

3.6.8 Network Provider Directory

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

- (1) names, as well as any group affiliations;
- (2) street addresses;
- (3) telephone numbers;
- (4) website URLs, as appropriate;
- (5) specialties, as appropriate;
- (6) whether Network Providers will accept new Enrollees;
- (7) the cultural and linguistic capabilities of Network Providers, including languages (including ASL) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training; and
- (8) whether Network Providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

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

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

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

3.6.9 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 his or her primary care, or was seen on a regular basis by the terminated Provider. Notice to the Enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or within 15 calendar days after receipt or issuance of the termination notice.

3.6.10 Sales and Transactions

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

3.7 Disenrollment Initiated by Enrollees

3.7.1 Disenrollment by Enrollees

Enrollees may disenroll from the HOME Program at any time.

3.7.2 Process for Requesting Health Plan Change

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

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

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

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

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

3.7.6 Enrollees in an Inpatient Hospital Setting

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

than eligibility on the Contractor Eligibility Transmission or the Enrollee is otherwise disenrolled under this Contract, the Contractor shall remain financially responsible for such care until discharge.

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

- (1) the Enrollee is on FFS at the time of admission to the inpatient hospital,
- (2) the Enrollee is in an inpatient hospital or nursing home at the time the Enrollee's eligibility starts with the Contractor, and
- (3) the Enrollee remains in the hospital or nursing home for longer than the first month enrollment with the plan.

3.8 Disenrollment Initiated by Contractor

3.8.1 Prohibition on Disenrollment for Adverse Change in Enrollee Health

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

3.8.2 Valid Reasons for Disenrollment

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

- (1) for reasons specifically identified in the Contractor's Enrollee handbook;
- (2) violation of responsibilities included in the Contractor's Enrollee handbook;
- (3) when the Enrollee ceases to be eligible for medical assistance under the State Plan in accordance with 42 USC 1396, *et seq.* and as finally determined by the Department;
- (4) upon termination or expiration of the Contract;
- (5) death of the Enrollee;
- (6) confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract;
- (7) violation of enrollment requirements developed by the Contractor and approved by the Department but only after the Contractor and/or the Enrollee has exhausted the Contractor's applicable internal Grievance procedure
- (8) As allowed by Article 1.3.22 of Attachment C.

3.8.3 Approval by the Department Required

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

3.8.4 Enrollee's Right to File a Grievance

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

3.8.5 Refusal of Re-Enrollment

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

3.8.6 Automatic Re-Enrollment

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

Article 4: Benefits

4.1 General Provisions

4.1.1 Basic Standards

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

(B) The Contractor shall 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 beneficiaries under FFS, as set forth in 42 CFR 440.230, and for Enrollees under the age of 21, as set forth in 42 CFR 440 Subpart B.

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

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

(E) The Contractor may place appropriate limits on a service on the basis of criteria applied

under the State Plan such as Medical Necessity, or for the purpose of utilization control, provided:

- (1) the services furnished can reasonably be expected to achieve their purpose;
- (2) the services supporting Enrollees with ongoing or chronic conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and
- (3) family planning services are provided in a manner that protects and enables an Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20.

4.1.2 Covered Services

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

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

- (1) services that address the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
- (2) the ability for an Enrollee to achieve age-appropriate growth and development;
- (3) the ability for an Enrollee to attain, maintain, or regain functional capacity; and
- (4) the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

4.2 Scope of Services

4.2.1 Scope of Covered Services

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

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

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

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

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

4.2.2 Changes to Benefits

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

4.2.3 Court and Administrative Orders Regarding Benefits

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

4.2.4 Reconstructive Procedures and Least Costly Alternative

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

- (1) a reconstructive procedure following disfigurement caused by trauma or Medically Necessary surgery;
- (2) a reconstructive procedure to correct serious functional impairments; or
- (3) performed because the otherwise non-Covered Service is more cost effective for the Medicaid Program than other alternatives.

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

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

4.3 Covered Services—Emergency Services

4.3.1 Emergency Services, Generally

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

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

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

(D) The Contractor may not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within 10 calendar days of presentation for Emergency Services.

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

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

4.3.2 Payment Liability for Emergency Services

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

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

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

4.3.3 Payment Liability in the Absence of a Clinical Emergency

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

expected the absence of immediate medical attention to result in one of the three outcomes listed in the definition of an Emergency Medical Condition.

4.3.4 Payment Liability for Referrals

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

4.4 Covered Services—Post-Stabilization Care

4.4.1 Post-Stabilization Care, Generally

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

4.4.2 Pre-Approved Post-Stabilization Care Services

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

4.4.3 Other Contractor-Liable Post-Stabilization Care Services

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

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

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

(2) the Contractor cannot be contacted; or

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

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

- (ii) a Contractor physician resumes responsibility for the Enrollee’s care;
- (iii) a Contractor representative and the treating physician reach an agreement concerning the Enrollee’s care; or
- (iv) the Enrollee is discharged.

4.4.4 Limitation on Charges to Enrollees

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

4.5 Covered Services -- Care Provided in Medical Institutions

4.5.1 Care Provided in Medical Institutions, Generally

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

4.5.2 Process for Stays Lasting 30 Days or Less

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

4.5.3 Process for Stays More than 30 Days

(A) When the Network Provider’s prognosis indicates an Enrollee requires care in a Medical Institution for more than 30 calendar days, the Contractor shall:

- (1) notify the Enrollee, hospital discharge planner, and Medical Institution that the Contractor shall not be responsible for the services provided for the Enrollee during the stay at the facility; and
- (2) notify BMHC of this determination and the BMHC shall change the status of the Enrollee to FFS.

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

(A) When the Network Provider’s initial prognosis of Medical Institution services was anticipated to be 30 calendar days or less, but during the 30 calendar day period the Contractor Network Provider determines that the Enrollee shall require Medical Institution services for more than 30 calendar days the Contractor shall:

- (1) notify the Medical Institution that a determination has been made that the Enrollee will require services for more than 30 calendar days; and
- (2) notify the BMHC of the determination that the Enrollee will require services in a

Medical Institution for more than 30 calendar days.

(B) The Contractor shall be responsible for payment for three working days after the Contractor has notified the Medical Institution that care will be required for more than 30 calendar days.

4.5.5 Failure to Disenroll

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

4.6 Covered Services – Hospice

4.6.1 Hospice, Generally

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

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

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

4.7 Covered Services—Inpatient Hospital Services for Scheduled Admissions

4.7.1 Financial Responsibility for Inpatient Hospital Services

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

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

4.8.1 Children in Custody of the Department of Human Services, Generally

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

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

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

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

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

4.8.3 Children in Custody, Initial Health Screening

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

4.8.4 EPSDT Exams

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

Care) exam in Utah.

4.9 Covered Services—Organ Transplantations

4.9.1 Organ Transplantations, Generally

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

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

4.9.2 Specific Organ Transplantations

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

4.9.3 Psycho-Social Evaluation Required

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

4.9.4 Out-of- State Transplantations

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

4.10 Excluded Services—Habilitative and Behavioral Management Services

4.10.1 Habilitative and Behavioral Management Services, Generally

Habilitative and behavioral management services are not Covered Services. If habilitative services are required, the Contractor shall have a process to refer the Enrollee to the Division of

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

4.11 Covered Services—Out-Of-State Transportation Services

4.11.1 Out-of-State Transportation, Generally

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

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

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

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

4.12.1 Identification of Enrollees with Special Needs

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

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

Article 5: Delivery Network

5.1 Availability of Services

5.1.1 Network Requirements

(A) The Contractor shall maintain and monitor a network of appropriate Network Providers that is supported by written agreements and is sufficient to provide adequate access to all Covered

Services for all Enrollees, including those with limited English proficiency or physical or mental disabilities. In establishing and maintaining the network of Network Providers the Contractor shall consider:

- (1) the anticipated Medicaid enrollment;
- (2) the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor’s Service Area;
- (3) the numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the Covered Services;
- (4) the number of Network Providers who are not accepting new Medicaid patients; and
- (5) the geographic location of Network Providers and Medicaid Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Medicaid Enrollees with disabilities.

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

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

5.1.2 Time and Distance Standards

(A) The Contractor shall maintain provider network adequacy time and distance standards to ensure patient access. The standards will be different for Frontier, Rural and Urban areas of the State. Wasatch Front Urban, Rural and Frontier areas of Utah are listed in the following table.

Urban Counties	Rural Counties	Frontier Counties
Cache	Summit	Tooele
Davis	Wasatch	
Salt Lake		
Utah		
Weber		

(B) Per CMS regulations, the Contractor shall ensure that Enrollees have access to the following types of providers within the time and distance standards.

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

(C) In light of the specialized services performed on-site at the HOME clinic, the Contractor is exempt from the time and distance standards when performing these on-site services. When a service is required to be performed off-site of the HOME clinic, the Contractor shall ensure the network adequacy standards described in 5.1.2 are met.

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

- (1) the specific exemption the Contractor is requesting;
- (2) the steps taken by the Contractor to comply with the network adequacy requirements before requesting the exception; and
- (3) a description of the Contractor's plan to adequately provide Covered Services in the area where the exemption is requested.

5.1.3 Women's Health Specialists

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

5.1.4 Second Opinions

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

5.1.5 Out of Network Services

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

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

5.1.6 Timely Access

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

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

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

5.1.7 Timely Access Monitoring

The Contractor shall establish mechanisms to ensure that its Network Providers are complying with the timely access requirements found in Article 10.2.6 and shall monitor its Network Providers regularly to determine compliance by Network Providers. If there is failure to comply,

the Contractor shall take corrective action.

5.2 Subcontracts and Agreements with Providers

5.2.1 Subcontracts, Generally

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

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

- (1) the activities and obligations, and related reporting responsibilities, are specified in the contract or written agreement between the Contractor and the Subcontractor; and
- (2) the contract or written arrangement between the Contractor and the Subcontractor must either provide for the revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determines that the Subcontractor has not performed satisfactorily.

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

- (1) comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions;
- (2) agree that the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract;
- (3) make available, for the purposes of an audit, evaluation, or inspection by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Enrollees;
- (4) agree that the right to audit by the Department, CMS, the Department of Health and Human Services Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
- (5) agree that if the Department, CMS, or the Department of Health and Human Services Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

5.2.2 Agreements with Providers and Subcontractors

(A) The Contractor shall inform Providers and Subcontractors at the time they enter into a contract about:

- (1) the Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424;
- (2) the Aggrieved Person's right to file Grievances and Appeals and the requirements and timeframes for filing;
- (3) the availability of assistance to the Enrollee with filing Grievances and Appeals;
- (4) the Aggrieved Person's right to request a State Fair Hearing after the Contractor has made a determination on the Enrollee's Appeal which is adverse to the Enrollee; and
- (5) if the Contractor makes an Adverse Benefit Determinations to reduce, suspend, or terminate services:
 - (i) that the Enrollee, the Enrollee's legal guardian or other authorized representative has the right to request that the services be continued pending the outcome of the Appeal or State Fair Hearing if the Enrollee requests continuation of services within the required timeframe; and
 - (ii) that if the Appeal or State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of services.

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

(C) The Contractors written agreements with its Subcontractors and Providers shall contain a provision stating:

- (1) that if the Provider or Subcontractor becomes insolvent or bankrupt, Enrollees shall not be liable for the debt of the Provider or Subcontractor; and
- (2) that the Enrollee shall not be held liable for Covered Services provided to the Enrollee for which:
 - (i) the Department does not pay the Contractor, or
 - (ii) the Department or the Contractor does not pay the individual or Provider that furnished the services under a contractual, referral or other arrangement

5.2.3 Additional Network Provider Requirements

(A) In accordance with Article 6.6, if the Contractor has a physician incentive plan with a physician or physician group, the Contractor shall ensure the Network Providers abide by the requirements of Section 1877(E)(3)(B) of the Social Security Act.

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

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

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

(E) The Contractor shall ensure its Network Providers are either enrolled with the Department as a FFS provider or are enrolled with the Department as a full or limited Medicaid provider.

5.2.4 Mandatory Network Contracts

(A) The Contractor must contract with:

- (1) a level one trauma facility
- (2) a trauma intensive care burn center that includes:
 - (i) an operating room;
 - (ii) burn therapy services;
 - (iii) outpatient departments;
 - (iv) support activities for burn survivors; and
 - (v) services for both adults and children.
- (3) Primary Children's Hospital

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

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with Medicaid

(A) The Contractor shall make a payment only to a Provider who is enrolled with the Department as a full or limited Medicaid Provider, except when the Provider is:

- (1) Non-Network provider under single case agreements;
- (2) involved in delivery of Emergency Services that does not meet the definition of a Network Provider per 42 CFR 439.2; or
- (3) a Network provider, pending enrollment with the Department, per 438.602 (b)(2).

(B) The Contractor may execute Network Provider agreements for up to 120 calendar days while the provider completes the enrollment process with Utah Medicaid.

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

- (1) the Department notifies the Contractor that the Network Provider cannot be enrolled;
or
- (2) the Provider notifies the Contractor that they cannot be enrolled by the Department; or
- (3) one 120-day period has expired without enrollment of the Provider by the Department.

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

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

5.3.2 Network Provider Selection

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

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

5.3.3 Credentialing and Re-Credentialing Policies and Procedures

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

- (1) Network Provider completion of Contractor written applications;
- (2) procedures for assuring that potential and current Network Providers are appropriately credentialed;
- (3) primary source verification of licensure and disciplinary status by the State of Utah and other States; and
- (4) procedures for viewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension, or exclusion.

5.3.4 Timeframe for Re-Credentialing

- (A) The Contractor shall have a re-credentialing process for Network Providers that:
- (1) is completed at least every three years; and
 - (2) updates information obtained during the initial credentialing process.

5.3.5 Notifications

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

5.3.6 Documentation

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

5.3.7 Non-Inclusion of Providers

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

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

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

5.3.8 Nondiscrimination

(A) Consistent with 42 CFR 438.214 and 42 CFR 438.12, the Contractor's Provider selection policies and procedures must not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment.

(B) Pursuant to 42 CFR 438.12, the Contractor shall not discriminate against Providers with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of that Provider's license or certification under applicable State law, solely on the basis of the Provider's license or certification. This may not be construed to mean that the Department:

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

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

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

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

5.3.9 Federally Qualified Health Centers

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

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

5.3.10 Network Provider Practice Guidelines, General Standards

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

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

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

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

(4) be reviewed and updated periodically as appropriate.

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

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

5.4 Payment of Provider Claims

5.4.1 General Requirements

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

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

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

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

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

5.4.2 Special Rules for Payment for Provider Preventable Conditions

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

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

5.4.3 Vaccines for Children Program

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

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

5.5 Prohibitions on Payment

5.5.1 Prohibitions on Payments for Excluded Providers

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

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

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

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

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

5.5.2 Additional Payment Prohibitions under Federal Law

(A) In accordance with Section 1903(i)(16), (17) and (18) of the Social Security Act, the Contractor is prohibited from paying for an item or service (other than emergency item or service, not including items or services furnished in an emergency room of a hospital):

(1) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

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

(3) for home health care services provided by an agency or organization, unless the agency provides the Contractor or the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

5.5.3 Availability of FFP

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

(1) the Contractor is controlled by a sanctioned individual as described in Section

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

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

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

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

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

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

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

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

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

(B) The Parties understand and agree that the Department must ensure that no payment is made to a Network Provider other than by the Contractor for Covered Services, except when these payments are specifically required to be made by the Department in Title XIX of the Social Security Act, in 42 CFR, or when the Department makes direct payments to Network Providers for graduate medical education costs approved under the State Plan.

Article 6: Program Integrity Requirements

6.1 Fraud, Waste, and Abuse

6.1.1 Fraud, Wast, and Abuse, Generally

(A) Pursuant to 42 CFR 438.608, the Contractor or Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of Claims, shall implement and maintain arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Waste, and Abuse on the part of the Providers, Enrollees, and other patients who falsely present themselves as being Medicaid eligible.

(B) The Contractor shall have a written compliance plan designed to identify and refer suspected Fraud, Waste, and Abuse activities. The Contractor shall submit the compliance plan to the Department by July 1st of each year for the Department's review and approval. If the Department does not respond with approval within 90 calendar days of the compliance plan due date, the plan will be deemed approved.

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

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

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

(F) The Contractor shall cooperate and coordinate with the Department, the Utah Office of Inspector General of Medicaid Services (Utah OIG), and MFCU in any Waste, Fraud, and Abuse activities and investigations.

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

6.1.2 Specific Requirements for Contractor's Management Arrangements or Procedures

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

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

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

- (3) the establishment of a regulatory compliance committee that is accountable to the board of directors and senior management charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract;
- (4) effective training and education for the compliance officer, Contractor's senior management, and the Contractor's employees for the Federal and State standards and requirements under this Contract;
- (5) effective lines of communication between the compliance officer and the Contractor's employees;
- (6) enforcement of standards through well-publicized disciplinary guidelines;
- (7) establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract;
- (8) provisions for internal monitoring and auditing including:
 - (i) mechanism(s) for verifying with Enrollees that Covered Services provided or reimbursed by the Contractor were actually furnished to Enrollees (such as periodic questionnaires, telephone calls, etc., to a sample of Enrollees); and
 - (ii) documentation of the sampling methodology and the schedule for conducting the verifications; and
- (9) provisions for prompt reporting to the Department of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud;
- (10) a provision for prompt notification to the Department when it receives information about changes in an Enrollee's circumstances that may affect eligibility including changes in residence or death of an Enrollee;
- (11) a provision for notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect that Network Provider's eligibility to participate in the Managed Care Program, including the termination of the Network Provider agreement with the Contractor;
- (12) as detailed in Article 6.2, provisions for written policies for all employees of the Contractor, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers;

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

(14) as detailed in Article 6.1.5, provision for the Contractor's suspension of payments to a Network Provider for which the Department determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23.

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

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

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

(C) Reports of Fraud, Waste, or Abuse made by the Contractor or a Provider shall be made to the Utah OIG or MFCU and the Department within fifteen working days of detection of the incident of Provider-related Fraud, Waste, or Abuse, subject to the exception for Waste in Utah Code Ann. 63A-13-501(1)(b).

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

- (1) name and identification number of the suspected individual;
- (2) source of the complaint (if anonymous, indicate as such);
- (3) type of Provider or type of staff position, if applicable;
- (4) nature of complaint;
- (5) approximate dollars involved, if applicable and
- (6) the legal and administrative disposition of the case, if any, including actions taken by law enforcement to whom the case has been referred.

(E) The Contractor shall submit to the Department on a quarterly basis, no later than 30 calendar days after each reporting period, a report that includes:

- (1) in accordance with 42 CFR 455.17(a), the number of complaints of Fraud, Waste, and Abuse that warranted a preliminary investigation; and
- (2) the Providers against which the Contractor has taken any adverse action for program integrity reasons.

6.1.4 Reporting Medicaid Member-Related Fraud, Waste, and 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 or maintain Medicaid eligibility), the Contractor or Provider shall report the potential Medicaid Member Fraud to the Utah Department of Workforce Services. All other types of potential Fraud and all types of potential Medicaid Member Waste or Abuse related to the Medicaid program shall be reported to the Utah OIG and to the Department.

6.1.5 Obligation to Suspend Payments to Providers in Cases of Fraud

- (A) The Contractor shall develop policies and procedures to comply with 42 CFR §455.23.
- (B) The Contractor shall contact MFCU prior to suspending payments.
- (C) If the Department suspends payments to a Provider, and the Department notifies the Contractor, the Contractor shall also suspend payments to that Provider until the Department lifts the suspension.

6.1.6 Service Verification

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

- (1) annually, the Contractor shall randomly select a minimum of 50 individual Enrollees who received a Covered Service during the state fiscal year for service verification; and
- (2) the Contractor shall keep a record of each Enrollee contacted for service verification.

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

- (1) the names and ID numbers of all Enrollees contacted for service verification;
- (2) whether the Enrollee was contacted via telephone, email, or other method;
- (3) whether the Enrollee responded to the service verification; and
- (4) whether the Enrollee indicated he or she obtained the service during the prior fiscal year.

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

6.1.7 Subrogation of Claims Arising from Fraud

The Contractor agrees to be subrogated to the state of Utah for any and all claims Contractor has or may have against pharmaceutical companies, retailers, Providers, or other Subcontractors,

medical device manufacturers, laboratories or durable medical equipment manufacturers in the marketing and pricing and quality of their products. The Contractor shall not be entitled to any portion of the recovery obtained by MFCU.

6.2 False Claims Act

6.2.1 False Claims Act, Generally

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

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

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

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

6.2.2 Information Required in False Claims Act Policies

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

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

6.2.3 Dissemination of False Claims Act Policies and Procedures

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

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

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

6.2.4 Employee Handbook

(A) If the Contractor has an employee handbook, the Contractor's handbook shall include:

- (1) a specific discussion of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs;
- (2) the rights of employees to be protected as whistleblowers; and
- (3) the Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

6.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

6.3.1 General Requirements

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

- (1) the Contractor shall not knowingly have a director, officer, partner, Subcontractor as governed by 42 CFR 438.230, Network Provider, or person with beneficial ownership of 5% or more of the Contractor's equity who is:
 - (i) debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or
 - (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.
- (2) The Contractor shall not knowingly have a Network Provider or an employment, consulting, or any other agreement with a person for the provision of items or services that are significant and material to the Contractor's obligations to the Department who is:
 - (i) debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order; or
 - (ii) an affiliate, as defined in the Federal Acquisition Regulation, of a person who is debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

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

6.3.2 Screening for Prohibited Affiliations

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

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

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

(2) Subcontractor as governed by 42 CFR 438.230;

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

(4) Network Providers; or

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

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

(1) conduct searches of the LEIE and EPLS databases and any other database required by the Department to determine if the individuals listed in Article 6.3.2(B)(1),(2), (3), (4), and (5) are debarred, Suspended, or otherwise Excluded; and

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

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

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

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

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

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

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

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

6.3.3 Reporting Prohibited Affiliations

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

(B) If the Contractor obtains a prohibited affiliation attestation form from an individual or entity stating that the individual or entity is an Affiliate, as defined by the Federal Acquisition Regulation, who has been debarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall provide an electronic copy of the attestation form to the Department no later than 30 calendar days from the date of the individual

providing the attestation to the Contractor.

(C) To ensure compliance with 42 CFR 1002.203, the Department, after having been notified of the Contractor's noncompliance:

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

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

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

6.4 Excluded Providers

6.4.1 Definition of Excluded Providers

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

6.4.2 Screening for Excluded Providers

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

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

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

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

(E) Once the Contractor has credentialed the potential Provider and enters into a Provider agreement, and the Provider is not Medicare-certified or is not a Medicaid Provider, the

Contractor may delegate:

- (1) searches of the Provider's director; and/or
- (2) searches of the Provider's providers who deliver Covered Services incident to the Provider's obligations under its agreements with the Contractor.

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

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

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

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

6.4.3 Excluded Provider Payment Prohibition

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

6.5 Disclosure of Ownership or Control Information

6.5.1 Disclosure Information

(A) Using the Department-specified disclosure form, and in accordance with 42 CFR 455.104, the Contractor, if organized as a corporation, shall provide disclosures for each Person with an Ownership or Control Interest in the Contractor.

(B) The disclosures for Persons with an Ownership or Control Interest shall include:

- (1) the person's name and address of any Person (individual or corporation) with an Ownership or Control Interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location and the P.O. Box address;
- (2) date of birth and Social Security Number (in the case of an individual);

(3) other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent or more interest;

(4) whether the Person (individual or corporation) with an Ownership or Control Interest in the Contractor is related to another Person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling;

(5) whether the Person (individual or corporation) with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent or more interest is related to another person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling; and

(6) the name of any Other Disclosing Entity (or Fiscal Agent or Managed Care Entity) in which an owner of the Contractor has an ownership or control interest.

(C) Using the Department-specified form, and in accordance with 42 CFR 455.104, the Contractor shall provide disclosures of Managing Employees that include the name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

(D) Government-owned Entities - If the Contractor is government-owned, the Contractor shall disclose anyone meeting the definition of a Managing Employee, and would only need to disclose board members if a board member meets the definition of a Managing Employee.

(E) Non-Profit Entities

(1) If the Contractor is a non-profit entity and organized as a corporation, the Contractor shall submit disclosures in accordance with this Article 6.1.5 (A);

(2) If the Contractor is a non-profit entity but not a corporation, the Contractor shall submit Managing Employee disclosures for all of the Contractor's individuals who meet the definition of a Managing Employee.

(F) Officers/Directors - Corporations Only

(1) Persons with an Ownership or Control Interest in the Contractor include officers and directors only if the Contractor is organized as a corporation. Corporations include for-profit corporations, non-profit corporations, closely-held corporations, limited liability corporations, and any other type of corporation authorized under State law. All officers and directors shall provide disclosures specified in this Article 6.5.1(A).

(2) If the Contractor is organized as a corporation, the term director refers to members of the board of directors. In such instances, if the Contractor has a director of finance who is not a member of the board of directors, the individual would not need to be disclosed as a director/board member. To the extent the individual meets the definition of a Managing Employee, the Contractor shall disclose the individual as a Managing Employee.

(3) The Contractor shall disclose all officers and directors regardless of the number and even if they serve in a voluntary capacity.

(4) If the Contractor is a non-profit corporation and has trustees instead of officers or directors, the Contractor shall disclose the trustees in accordance with this Article 6.5.1(A).

(5) The Contractor shall only disclose officers and directors of the Contractor. If the Contractor has indirect owner(s), the Contractor need not disclose the officers and directors of the indirect owner(s). If the indirect owner(s)' officers, directors or board members also serve as the Contractor's officers, directors or board members, then the Contractor shall disclose the indirect owner(s)'s officers, directors or board members in accordance with this Article 6.5.1(A).

(6) Partners

(i) The Contractor shall disclose all general and limited partnership interests, regardless of the percentage.

(ii) The Contractor shall only disclose partnership interest in the Contractor. The Contractor need not report partnership interests in the Contractor's indirect owner(s). If the partnership interest in the indirect owner(s) results in a greater than five percent indirect ownership interest in the Contractor, this indirect ownership interest must be disclosed in accordance with this Article 6.5.1(A).

(G) Disclosure by Individuals in Other Capacity - Although an individual or entity may not qualify as an officer, director, or partner, and need not be disclosed as a Person with an Ownership or Control Interest in the Contractor, the party may need to be disclosed as a Managing Employee in accordance with this Article 6.5.1(B).

6.5.2 Reporting Timeframes

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

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

(2) upon the Contractor executing the Contract with the Department;

(3) upon renewal or extension of the Contract;

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

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

(B) The Department shall review the ownership and control disclosure submitted by the

Contractor and any of its Subcontractors as required in 42 CFR 438.608(c).

6.5.3 Consequences for Failure to Provide Disclosures

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

6.6 Disclosure of Physician Incentive Plans

6.6.1 Disclosure of Physician Incentive Plans, Generally

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

6.6.2 Prohibition

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

6.6.3 Reporting Requirements

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

(B) To determine whether the incentive plan complies with the regulatory requirements, the Contractor shall report to the Department:

- (1) whether services not furnished by the physician or physician group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group;
- (2) the type of incentive arrangement (e.g., withhold, bonus, capitation arrangement, etc.);
- (3) the percent of withhold or bonus, if applicable;
- (4) the panel size, and if Enrollees are pooled, the method used;
- (5) if the physician or physician group is at substantial financial risk, proof the physician/group has adequate stop-loss coverage, including the amount and type of stop-loss; and
- (6) if required to conduct Enrollee surveys, the survey results.

6.6.4 Substantial Financial Risk

If the physician/group is put at substantial financial risk for services not provided by the

physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual Enrollee surveys.

6.6.5 Information to Enrollees

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

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

7.1 Service Authorization and Notice of Adverse Benefit Determination

7.1.1 Policies and Procedures for Service Authorization Requests

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

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

(C) The Contractor shall require that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Enrollee's medical, behavioral, or long-term services and supports needs.

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

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

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

7.1.2 Timeframes and Procedures for Standard Service Authorizations

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

(B) The Contractor may extend the timeframe for making the decision by up to an additional 14

calendar days if:

- (1) the Enrollee or the Provider requests an extension; or
- (2) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's best interest.

(C) If the Contractor extends the timeframe for making standard Service Authorization decisions the Contractor shall:

- (1) give the Enrollee written notice of the reason for the decision to extend the timeframe;
- (2) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and
- (3) issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.3 Timeframes and Procedures for Denying All or Part of a Service Authorization Request

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

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

- (1) the Enrollee or the Provider requests an extension; or
- (2) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's best interest.

(C) If the Contractor extends the timeframe for making standard Service Authorization decisions the Contractor shall:

- (1) give the Enrollee written notice of the reason for the decision to extend the timeframe;
- (2) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and
- (3) issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.4 Timeframes and Procedures for Expedited Service Authorization Decisions

(A) For cases in which a Provider indicates, or the Contractor determines (on request from an

Enrollee) that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor:

(1) shall make an expedited service authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the receipt of the Service Authorization Request; and

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

(i) the Enrollee requests the extension; or

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

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

7.1.5 Service Authorization Decisions Not Reached Within Required Timeframes

In the event that the Contractor fails to make a service authorization decision within the prescribed timeframes, such failure shall constitute a denial of services and shall be considered an Adverse Benefit Determination. The Contractor is required send out a Notice of Adverse Benefit Determination to the Enrollee and the Provider on the day that the timeframe expires.

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

(A) If the Contractor seeks to reduce, suspend, or terminate previously authorized Covered Services, this constitutes an Adverse Benefit Determination.

(B) The Contractor shall notify the requesting Provider and mail a Notice of Adverse Benefit Determination to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following timeframes:

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

(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:

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

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

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

(b) the Enrollee gives information that requires termination or reduction of

services and indicates that the Enrollee understands that this shall be the result of supplying that information;

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

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

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

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

7.2 Other Adverse Benefit Determinations Requiring Notice of Adverse Benefit Determination

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

(A) The Contractor shall provide a written Notice of Adverse Benefit Determination to the requesting Provider of decisions to deny payment in whole or in part but not if the denial, in whole or in part, of a payment for a service is solely because the Claim does not meet the definition of a Clean Claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

7.3 Required Content of Notice of Adverse Benefit Determination

7.3.1 Required Content of Notice of Adverse Benefit Determination, Generally

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

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

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

- (2) the reason for the Adverse Benefit Determination;
- (3) the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination (such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits);
- (4) the date the Adverse Benefit Determination will become effective when the Adverse Benefit Determination is to terminate, suspend, or reduce a previously authorized Covered Service;
- (5) the right to request an Appeal of the Adverse Benefit Determination with the Contractor;
- (6) the procedures for requesting an Appeal;
- (7) the circumstances under which expedited resolution of an Appeal is available and how to request an expedited Appeal resolution;
- (8) the Enrollee's right to have disputed services continue pending resolution of the Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider;
- (9) how to request that the disputed services be continued, and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is adverse to the Enrollee, to the extent that they were furnished solely because of this Contract requirement in accordance with 42 CFR 438.420; 438.404(b)(6), and 431.230(b); and
- (10) the following timeframe for filing an Appeal, as applicable:
 - (i) if the Enrollee is not requesting continuation of disputed services pending resolution of an Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider, and the original period covered by the original authorization has not expired, the Enrollee or the Provider, shall file the Appeal within 60 calendar days from the date on the Contractor's Notice of Adverse Benefit Determination; or
 - (ii) if the Enrollee is requesting continuation of disputed services pending resolution of an Appeal of an Adverse Benefit Determination to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider, and the original period covered by the original authorization has not expired, the Enrollee or Provider shall file the Appeal on or before the later of the following:
 - (a) within 10 calendar days of the Contractor mailing the Notice of

Adverse Benefit Determination; or

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

7.3.2 Attachment to Notice of Adverse Benefit Determination – Written Appeal Request Form

(A) The Contractor shall develop and include as an attachment to the Notice of Adverse Benefit Determination an Appeal request form that an Aggrieved Person may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Aggrieved Person chooses to submit a written request for an expedited Appeal resolution, even though an oral request is all that is required. The form shall:

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

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

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

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

(3) summarize the assistance available to the Aggrieved Person to complete the Appeal request form and how to request the assistance; and

(4) Include information on how the Appeal Request Form can be submitted promptly (email, fax, etc.).

(B) When the Contractor is required to inform the Aggrieved Persons of their State Fair Hearing rights, the Contractor shall attach the State's Medicaid State Fair Hearing request form.

Article 8: Grievance and Appeal Systems

8.1 Overall System

8.1.1 General Requirements

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

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

(2) an Appeal process whereby an Aggrieved Person may file an Appeal of an Adverse Benefit Determination; and

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

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

(C) To the extent that any written notice is required by Articles 8.1, 8.2, 8.3, 8.4 and 8.5, the Contractor shall provide notices to the affected parties.

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

(A) The Contractor's process for Appeals shall have only one level of review and shall:

(1) provide that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as an Appeal request;

(2) include as parties to the Appeal:

(i) the Enrollee and the Enrollee's representative, or

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

8.3 Standard Appeals Process

8.3.1 Authority to File

An Aggrieved Person may file an Appeal either orally or in writing.

8.3.2 Timing

The Aggrieved Person may file an Appeal within 60 calendar days from the date on the Contractor's written Notice of Adverse Benefit Determination.

8.3.3 Procedures

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

(B) The Contractor shall give the Aggrieved Person any reasonable assistance in completing required forms for submitting a written Appeal and taking other procedural steps related to an Appeal. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.

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

(D) The Contractor shall provide the Aggrieved Person reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Aggrieved Person of the limited time available for this sufficiently in advance of the resolution timeframe for the Appeal.

(E) The Contractor shall provide the Aggrieved Person the opportunity, before and during the 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 Appeal. The Contractor shall provide this information free of charge and sufficiently in advance of the resolution timeframe.

(F) The Contractor shall include as parties to the Appeal the Enrollee and the Enrollee's representative or the legal representative of a deceased Enrollee's estate.

(G) The Contractor shall ensure that the individuals who make the decision on an Appeal are individuals who:

(1) were neither involved in any previous level of review or decision-making nor subordinate of any such individual;

(2) who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease in regards to:

(i) an Appeal of a denial that is based on lack of Medical Necessity; or

(ii) an Appeal that involves clinical issues; and

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

8.3.4 Timeframes for Appeal Resolution and Notification

(A) The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from the day the Contractor receives the Appeal request.

(B) The Contractor may extend the timeframe for resolving the Appeal and providing notice by up to 14 calendar days if:

(1) the Aggrieved Person requests the extension; or

(2) the Contractor shows that (to the satisfaction of the Department, upon its request) there is no need for additional information and how the delay is in the Aggrieved Person's interest.

(C) If the Contractor extends the timeframe and the extension was not requested by the Aggrieved Person, the Contractor shall:

- (1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;
- (2) give the Aggrieved Person written notice, within two calendar days, of the reason for the Decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and
- (3) complete the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.3.5 Format and Content of Notice of Appeal Resolution

(A) The Contractor shall provide written Notice of Appeal Resolution to the affected parties in accordance with format and language requirements found in 42 CFR 438.10. The written Notice of Appeal Resolution shall include:

- (1) the results of the Appeal process and the date it was completed; and
- (2) for Appeals not resolved wholly in favor of the Aggrieved Person, the Contractor shall include the following in the written Notice of Appeal Resolution:
 - (i) the right to request a State Fair Hearing and how to do so;
 - (ii) the right to request continuation of disputed services if the Appeal decision is to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized Provider and the original period covered by the original authorization has not expired;
 - (iii) how to request continuation of disputed services;
 - (iv) a statement that the Enrollee may be liable for the cost of disputed services provided if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination;
 - (v) the timeframe for requesting a State Fair Hearing when continuation of disputed services is not requested and when continuation of disputed services is requested; and
 - (v) a copy of either the Medicaid State Fair Hearing request form.

8.3.6 Continuation of Disputed Services During Appeal

(A) In accordance with 42 CFR 438.420, 738.404(b)(6), and 431.230(b), the Contractor shall continue the Enrollee's disputed services during the Appeal if:

- (1) the Adverse Benefit Determination being appealed 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 Service Authorization Request has not expired;

(4) the Aggrieved Person files the Appeal timely, which means filing the Appeal on or before the later of the following:

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

(ii) by the intended effective date of the Contractor's proposed Adverse Benefit Determination; and

(5) the Aggrieved Person requests continuation of disputed services in the Appeal request.

8.3.7 Duration of Continued Disputed Services and Enrollee Responsibility

(A) If the Contractor continues the Enrollee's disputed services, the Contractors shall continue the disputed services until one of the following occurs:

(1) the Aggrieved Person withdraws the Appeal or State Fair Hearing request;

(2) ten days pass after the Contractor mails written Notice of Appeal Resolution that is adverse to the Aggrieved Person and within that 10 day time period, and the Aggrieved Person does not request a State Fair Hearing with continuation of disputed services until a State Fair Hearing decision is reached; or

(3) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person.

(B) If the final resolution of the Appeal or State Fair Hearing is adverse to the Aggrieved Person, 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 during the pendency of the Appeal or State Fair Hearing to the extent the services were furnished solely in accordance to the requirements found in Article 8.4.8 of this Contract and in accordance with 42 CFR 431.230(b).

8.3.8 Reversed Appeal Resolutions

(A) If the Contractor or State Fair Hearing officer reverses an action to deny, limit, or delay services that were not furnished while the Appeal or State Fair Hearing was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

(B) If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal or State Fair Hearing was pending, the Contractor shall pay for those services in accordance with the Department's policy and regulations.

8.4 Process for Expedited Resolution of Appeals

8.4.1 Process for Expedited Resolution of Appeals, Generally

(A) The Contractor shall establish and maintain an expedited Appeal process when:

(1) the Contractor determines, based either upon a request from an Aggrieved Person or in the Contractor's own judgment, that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function; or

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

8.4.2 Authority to File

The Aggrieved Person may file an expedited Appeal request either orally or in writing.

8.4.3 Timing

(A) The Aggrieved Person may file an Appeal of an Adverse Benefit Determination within 60 days from the date on the Contractor's Notice of Adverse Benefit Determination;

(B) If the Adverse Benefit Determination being appealed is to terminate, suspend or reduce a previously authorized course of treatment, the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired, and the Enrollee wants disputed services to continue during the Appeal process, then the Enrollee shall file the Appeal on or before the later of the following:

(1) within 10 days of the Notice of Adverse Benefit Determination; or

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

8.4.4 Procedures for an Expedited Appeal

(A) When an Aggrieved Person requests an expedited resolution of an Appeal, the Contractor shall inform the Aggrieved Person of the limited time available for the Enrollee to present evidence and testimony and make legal and factual arguments in person and in writing.

(B) The Contractor shall ensure that punitive action is not taken against a Provider who either requests an expedited resolution to an Appeal or supports an Enrollee's Appeal.

(C) The Contractor shall give the Aggrieved Person any reasonable assistance in making an expedited appeal. Reasonable assistance includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(D) The Contractor shall acknowledge receipt of the request for expedited Appeal resolution either orally or in writing and explain to the Aggrieved Person the process that must be followed to complete the Appeal.

(E) The Contractor shall ensure that the individuals who make the decision on an Appeal are individuals who:

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

(2) if deciding any of the following, are health care professionals who have appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:

(i) an Appeal of a denial that is based on lack of Medical Necessity; or

(ii) an Appeal that involves clinical issues; and

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

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

(G) The Contractor shall provide the Aggrieved Person the opportunity, before and during the expedited Appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the Appeals process and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. The Contractor shall provide this information free of charge and sufficiently in advance of the resolution timeframe.

8.4.5 Denial of a Request for Expedited Appeal Resolution

(A) If the Contractor denies a request for an expedited resolution of an Appeal, the Contractor shall:

(1) complete the Appeal using the standard timeframe of no longer than 30 calendar days from the day the Contractor receives the Appeal, with a possible 14 calendar day extension for resolving the Appeal and Providing Notice of Appeal resolution to affected parties;

(2) make reasonable effort to give the Aggrieved Person prompt oral notice of the denial; and

(3) mail written notice within two calendar days explaining the denial, specifying the standard timeframe that must be followed, and informing the affected parties that the Enrollee may file a Grievance regarding the denial of expedited resolution of an Appeal.

8.4.6 Timeframe for Expedited Appeal Resolution and Notification

(A) The Contractor shall complete each expedited Appeal and provide notice to affected parties

as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the Contractor receives the expedited Appeal request.

(B) The Contractor may extend the timeframe for completing the Appeal and providing notice by up to 14 calendar days if:

- (1) the Aggrieved Person requests the extension; or
- (2) the Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest (upon Department request).

(C) If the Contractor extends the timeframe and the extension was not requested by the Aggrieved Person the Contractor shall:

- (1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay;
- (2) give the Aggrieved Person written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the Aggrieved Person of the right to file a Grievance about the decision; and
- (3) resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

8.4.7 Format and Content of Expedited Appeal Resolution Notice

(A) The Contractor shall make reasonable effort to provide oral notice of the expedited resolution in addition to providing a written Notice of Appeal Resolution.

(B) The Contractor shall provide a written notice of Appeal Resolution that meets the same format and content requirements found in Article 8.3.5 of this Contract.

8.4.8 Continuation of Disputed Services During the Expedited Appeals Process

(A) The Contractor shall continue the Enrollee's disputed services during the expedited Appeal process if:

- (1) the Adverse Benefit Determination being appealed is to terminate, suspend or reduce a previously authorized course of treatment;
- (2) the services were ordered by an authorized Provider;
- (3) the original period covered by the original authorization has not expired;
- (4) the Enrollee, authorized representative or Provider files the Appeal timely, which means filing the Appeal on or before the later of the following:
 - (i) within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination; or
 - (ii) by the intended effective date of the Contractor's proposed Adverse Benefit

Determination; and

(5) the Enrollee or authorized representative requests continuation of disputed services in the Appeal request.

8.4.9 Duration of Continued Disputed Services and Enrollee Responsibility

(A) If the Contractor continues the Enrollee's disputed services, the Contractors shall continue the disputed services until one of the following occurs:

(1) the Aggrieved Person withdraws the Appeal;

(2) ten days pass after the Contractor mails written Notice of Appeal Resolution that is adverse to the Enrollee and within that 10 calendar day time period, and the Aggrieved Person does not request a State Fair Hearing with continuation of disputed services until a State Fair Hearing decision is reached; or

(3) a State Fair Hearing officer issues a hearing decision adverse to the Aggrieved Person.

(B) If the final resolution of the Appeal or State Fair Hearing is adverse to the Enrollee, that is, the decision upholds the Contractor's Adverse Benefit Determination, the Contractor or Provider may, consistent with the Department's usual policy on recoveries and consistent with this Contract, recover the cost of the disputed service furnished to the Enrollee while the Appeal or State Fair Hearing was pending to the extent the services were furnished solely because they were furnished according to the requirements found in Article 8.4.8 of this Contract and in accordance with 42 CFR 431.230(b).

8.4.10 Reversed Appeal Decisions

(A) If the Contractor or State Fair Hearing officer reverses an Adverse Benefit Determination to deny, limit, or delay services that were not furnished while the Appeal or State Fair Hearing was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

(B) If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal or State Fair Hearing was pending, the Contractor shall pay for those services in accordance with State policy and regulations.

8.5 State Fair Hearings

8.5.1 General Procedures

(A) When the Aggrieved Person has exhausted the Contractor's Appeal process and a final decision has been made, the Contractor shall provide written notification to the Aggrieved Person who initiated the Appeal of the outcome and explain in clear terms a detailed reason for

the denial.

(B) The Contractor shall provide notification to Aggrieved Person that the final decision of the Contractor may be appealed to the Department and shall give to the Aggrieved Person the Department's form to request a State Fair Hearing request form. The Contractor shall inform the Aggrieved Person the timeframe for requesting a State Fair Hearing as follows:

(1) The Department permits the Aggrieved Person, consistent with Utah Administrative Code R410-14-1, *et seq.*, to request a State Fair Hearing within 120 days from the date of the Contractor's Notice of Appeal Resolution.

(2) If the Enrollee chooses to continue disputed services (when a previously authorized course of treatment has been terminated, suspended or reduced) pending the outcome of the State Fair Hearing and the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired, the request for a State Fair Hearing and continuation of disputed services shall be submitted within 10 days after the Contractor mails the Notice of Appeals Resolution.

(C) As allowed by law, the parties to the State Fair Hearing include the Contractor as well as the Enrollee and the Enrollee's representative who may include legal counsel, a relative, a friend or other spokesman, or the representatives of a deceased Enrollee's estate.

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

(E) The parties to the State Fair Hearing shall be given the opportunity to:

- (1) bring witnesses;
- (2) establish all pertinent facts and circumstances;
- (3) present an argument without undue interference; and
- (4) question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

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

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

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

- (1) The State Fair Hearing shall take final administrative action within 90 days of the

earlier of:

(i) the date the Enrollee filed an appeal with the Contractor, not including the number of days the Enrollee took to subsequently file for a State Fair Hearing; or

(ii) where permitted, the date the Enrollee filed for direct access to a State Fair Hearing;

(2) The State Fair Hearing shall take final administrative action as expeditiously as the Enrollee's health condition requires, but no later than 3 working days after the Department receives from the Contractor the case file and information for any appeal of denial of a service that, as indicated by the Contractor:

(i) meets the criteria for expedited resolution as set forth in 42 CFR 438.410(a), but was not resolved within the timeframe for expedited resolution; or

(ii) was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the Enrollee.

8.6 Grievances

8.6.1 Authority to File a Grievance

An Enrollee, the Enrollee's legal guardian or other authorized representative, or a Provider may file a Grievance with the Contractor.

8.6.2 Procedures

(A) The Enrollee or the Provider may file a Grievance orally or in writing, at any time, with the Contractor.

(B) The Contractor shall give Enrollees any reasonable assistance in completing required forms for submitting a written Grievance or taking other procedural steps. Reasonable assistance includes, but is not limited to auxiliary aids upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(C) The Contractor shall acknowledge receipt of the Grievance either orally or in writing.

(D) The Contractor shall ensure that the individuals who make the decision on a Grievance are individuals who:

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

(2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:

(i) a Grievance regarding denial of a request for an expedited resolution of an

Appeal; or

(ii) a Grievance that involves clinical issues; and

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

8.6.3 Timeframes for Grievance Disposition and Notification

(A) The Contractor shall dispose of each Grievance and provide notice to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 90 calendar days from the day the Contractor receives the Grievance.

(B) For written Grievances, the Contractor shall notify the affected parties in writing of the disposition of the Grievance. For Grievances received orally, the Contractor shall notify the affected parties of the disposition either orally or in writing. The Notice of Grievance disposition shall satisfy 42 CFR 438.10.

(C) If the Enrollee, authorized representative, or a Provider files a Grievance with the Department, the Department shall apprise the individual or the Provider, of the Enrollee's right to file the Grievance with the Contractor and how to do so.

(1) If the individual or Provider prefers, the Department shall promptly notify the Contractor of the Enrollee's Grievance.

(2) If the Contractor receives the Grievance from the Department, the Contractor shall follow the procedures and timeframes outlined above for Grievances.

(3) If the Contractor receives the Grievance from the Department, the Contractor shall notify the affected parties and the Department, in writing, of the disposition of the Grievance.

(D) The Contractor may extend the timeframe for disposing of the Grievance and providing notice by up to 14 calendar days if:

(1) the Enrollee requests the extension; or

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

(E) If the Contractor extends the 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) give the Enrollee written notice, within two calendar days, of the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance about the decision.

8.7 Dispute Resolution, Reporting and Documentation

8.7.1 Reporting Requirements

(A) The Contractor shall maintain complete records of all Appeals and Grievances and submit semi-annual reports summarizing Appeals and Grievances using Department specified reporting templates. The Contractor shall separately track Grievances and Appeals that are relating to Children with Special Health Care Needs.

(B) The Contractor shall provide to the Department a summary of information on the number of Appeals and indicate the number of Appeals and Grievances that have been resolved. The Contractor shall include an analysis of the type and number of Appeals and Grievances.

8.7.2 Document Maintenance, Appeals

(A) The Contractor shall accurately, and in a manner accessible to the Department and available upon request to CMS, maintain all documentation relating to Appeals which includes, but is not limited to the following:

- (1) a general description of the reason for the Appeal;
- (2) the name of the Enrollee for whom the Appeal was filed;
- (3) written Notices of Adverse Benefit Determination;
- (4) a log of all oral Appeals and oral requests for expedited resolution of Appeals including:
 - (i) date of the oral requests;
 - (ii) date of acknowledgement of oral requests for expedited resolution of Appeals and method of acknowledgment (orally or in writing);
 - (iii) date of denials of requests for expedited Appeals resolution; and
- (5) copies of written standard Appeal requests;
- (6) copies of written notices of denial of requests for expedited Appeal resolution;
- (7) date of acknowledgement of written standard Appeal requests and method of acknowledgment (orally or in writing);
- (8) copies of written notices when extending the timeframe for adjudicating standard or expedited Appeals when the Contractor initiates the extension;
- (9) date of each review, or if applicable, review meeting;
- (10) resolution and date of resolution at each level, if applicable;
- (11) name of 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 provision governing Appeals.

8.7.3 Document Maintenance, Grievances

(A) Using its previously established verbal complaint logging and tracking system, the Contractor shall log all oral Grievances and include the following:

(1) general description of the reason for the Grievance;

(2) date the Grievance was received;

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

(4) name of the person taking the Grievance;

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

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

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

(8) name of person resolving the Grievance; and

(9) date the Enrollee was notified of the resolution and how the Enrollee was notified (either orally or in writing). If the Enrollee was notified of the disposition in writing, the Contractor shall maintain a copy of the written notification.

(B) The Contractor shall accurately, and in a manner accessible to the Department and available upon request to CMS, maintain all written Grievances and copies of the written notices of resolution to the affected parties.

Article 9: Enrollee Rights and Protections

9.1 Written Information on Enrollee Rights and Protections

9.1.1 General Requirements

(A) The Contractor shall develop and maintain written policies regarding Enrollee rights and protections.

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

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

(D) The Contractor and the Department shall ensure Enrollees are free to exercise their rights, and that the exercise of those rights shall not adversely affect the way the Contractor and its Network Providers treat Enrollees by including this statement in its Enrollee handbook.

9.1.2 Specific Enrollee Rights and Protections

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

- (1) the right to receive information about Contractor's Health Plan;
- (2) the right to be treated with respect and with due consideration for 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 treatment decisions regarding the Enrollee's health care, including the right to refuse treatment;
- (5) the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- (6) if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, the right to request and receive a copy of the Enrollee's medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.524 and 45 CFR 164.526;
- (7) the right to be furnished health care services in accordance with access and quality standards; and
- (8) the right to be free to exercise all rights and that by exercising those rights, the Enrollee shall not be adversely treated by the Department, the Contractor, and its Network Providers.

9.2 Network Provider-Enrollee Communications

9.2.1 General Requirements

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

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

- (3) the risks, benefits, and consequences of treatment or non-treatment; and
- (4) the Enrollee’s right to participate in decisions regarding the Enrollee’s health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 Generally

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

- (1) furnish information to the Department about the services it does not cover prior to signing this Contract or whenever it adopts the policy during the term of the Contract;
- (2) furnish the information to Potential Enrollees, before and during enrollment and to Enrollees, within 90 days after adopting the policy with respect to any service; and
- (3) notify Enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.

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

9.4 Advance Directives

9.4.1 Generally

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

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

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

Article 10: Contractor Assurances

10.1 General Assurances

10.1.1 Nondiscrimination

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

- (1) ensure the Contractor complies with Federal Laws and Regulations regarding nondiscrimination; and
- (2) take Grievances from Enrollees alleging nondiscrimination violations based on race, color, national origin, sex, sexual orientation, gender identity, disability, religion, or age.

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

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

10.1.2 Member Services Function

(A) The Contractor shall operate a Member Services function during Mountain Time regular business hours.

(B) As necessary, the Contractor shall provide ongoing training to ensure that the Member Services staff is conversant in the Contractor's policies and procedures as they relate to Enrollees.

(C) At minimum, Member Services staff shall be responsible for the following:

- (1) explaining the Contractor's rules for obtaining services;
- (2) assisting Enrollees to select or change Primary Care Providers; and
- (3) fielding and responding to Enrollee questions including questions regarding Grievances.

(D) The Contractor shall conduct ongoing assessment of its orientation staff to determine staff members' understanding of the Health Plan and its Medicaid managed care policies and provide training, as needed

10.1.3 Provider Services Function

(A) The Contractor shall operate a Provider services function during Mountain Time regular business hours.

(B) At a minimum, Provider services staff shall be responsible for the following:

- (1) training, including ongoing training, of the Contractor's Providers on Medicaid rules and regulations that shall enable Providers to appropriately render services to Enrollees;
- (2) assisting Providers to verify whether an individual is enrolled with the Health Plan;

- (3) assisting Providers with prior authorizations and referral protocols;
- (4) assisting Providers with claims payment procedures, including training Providers on how to bill using the National Provider Identification Number or the Department-assigned atypical provider identification number that is known to Medicaid to avoid rejection of Encounters; and
- (5) fielding and responding to Provider questions and the Grievance and Appeals System.

10.1.4 Enrollee Liability

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

- (1) The debts of the Contractor if it should become insolvent.
- (2) Covered Services provided to the Enrollee, for which:
 - (i) the Department does not pay the Contractor, or
 - (ii) the Department or the Contractor does not pay the individual or Provider that furnished the services under a contractual, referral, or other arrangement.
- (3) The payments to Providers that furnish Covered Services under a contract or other agreement with the Contractor that are in excess of the amount that normally would be paid by the Enrollee if service had been received directly from the Contractor.

10.2 Contractor Assurances Regarding Access

10.2.1 Documentation Requirements

- (A) The Contractor shall provide the Department adequate assurances and supporting documentation that demonstrates the Contractor has the capacity to serve the expected enrollment in its Service Area with the Department's standards for access to care found in section 5.1.2.
- (B) The Contractor shall provide the Department documentation, in a format specified by the Department, that the Contractor offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of Enrollees for the Service Area, maintains a network of Network Providers that is sufficient in number, mix and geographic distribution to meet the anticipated number of Enrollees in the Service Area.
- (C) The Contractor shall submit to the Department the documentation assuring adequate capacity and services in the Department specified format no less frequently than:
- (1) at the time it enters into a contract with the Department;
 - (2) on an annual basis; or
 - (3) at any time there has been a significant change (as defined by the Department) in the Contractor's operations that would affect adequate capacity and services including

changes in services, benefits, geographic Service Area or payments, or enrollment of a new population in the Health Plan.

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

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

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

(C) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, Telecommunication Devices for the Deaf (TTY/TDD), and other auxiliary aids and services to all Enrollees as needed at no cost.

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

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

10.2.3 Interpretive Services

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

(B) The Contractor shall ensure that interpretive services are provided in compliance with 45 CFR 92.201.

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

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

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

10.2.4 Cultural Competence Requirements

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

(B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and Network Providers which respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Network Providers. Culturally competent care is care given by a Network Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background and beliefs.

(D) The Contractor shall strive to ensure its Network Providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to Network Providers regarding how to promote the benefits of health care services as well as training about health care attitudes, beliefs, and practices that affect access to health care services.

10.2.5 No Restriction on Provider's Ability to Advise and Counsel

(A) The Contractor may not restrict a health care Provider's ability to advise and counsel Enrollees about Medically Necessary treatment options.

(B) All Providers acting within the Provider's scope of practice, shall be permitted to freely advise an Enrollee about the Enrollee's health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

10.2.6 Waiting Time Benchmarks

(A) The Contractor shall adopt benchmarks for waiting times for physician appointments as follows:

(1) Benchmarks for waiting times for appointments with a Primary Care Provider are:

- (i) within 30 days for a routine, non-urgent appointments;
- (ii) within 30 days for school physicals; and
- (iii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office).

(2) Benchmarks for waiting times for appointments with a specialist are:

- (i) within 30 days for non-urgent care; and
- (ii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office).

(B) These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

(C) The Contractor shall annually attest that waiting time benchmarks in Article 10.2.6(A) have been met and specify the method for verification using a Department-specified format.

10.3 Coordination and Continuity of Care

10.3.1 In General

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

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

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

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

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

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

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

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

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

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

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

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

10.3.2 Primary Care

(A) The Contractor shall implement procedures to deliver Primary Care to and coordinate health care services for all Enrollees.

(B) The Contractor shall implement procedures to ensure that each Enrollee has an ongoing source of Primary Care appropriate to the Enrollee's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee. The Contractor shall provide the Enrollee information on how to contact the Enrollee's designated person or entity.

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

(D) If an Enrollee's Primary Care Provider ceases to participate in the Contractor's network, the Contractor shall offer the Enrollee the opportunity to select a new Primary Care Provider.

10.3.3 Prepaid Mental Health Plan

(A) When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the Contractor and Prepaid Mental Health Plan shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

(B) The Contractor shall educate its Network Providers regarding an effective model of coordination between physical and mental health care services. The Contractor shall ensure its Network Providers coordinate the provision of physical health care services with mental health care services as appropriate.

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

(D) Clients enrolled in the Health Plan and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, shall have access to such services in a timely fashion. The Contractor and Prepaid Mental Health Plan shall reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

10.4 Billing Enrollees

10.4.1 Enrollee Billing, Generally

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

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

10.4.2 Circumstances in Which an Enrollee May Be Billed

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

(B) A non-Covered Service is a service that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee (e.g., more expensive eyeglass frames, hearing aids, custom wheelchairs, etc.) but does not meet the Medical Necessity criteria for amount duration, and scope as set forth in the State Plan or is not authorized by the Contractor.

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

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

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

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

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

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

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

10.4.3 Prohibition on Holding Enrollee's Medicaid Card

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

10.4.4 Medical Cards, Generally

If the Contractor elects to print its own cards for Enrollees, the Contractor and its Network Providers may not require the Enrollee to present their Contractor-printed card at the time of service. The only card that the Contractor may require is the Medicaid card issued by the Department.

10.4.5 Criminal Penalties

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

10.5 EPSDT Requirements

10.5.1 General EPSDT Requirements

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

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

Article 11: Payments

11.1 General Payment Provisions

11.1.1 Comprehensive Risk Contract

This Contract is a Comprehensive Risk Contract.

11.1.2 Payment Methodology

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

11.1.3 Contract Maximum

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

11.1.4 Payment Recoupment

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

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

11.1.5 Overpayments to Providers

(A) The Contractor shall have written policies and procedures that specify:

(1) that the Contractor shall report to the Department within 60 calendar days when it or any Subcontractor has identified subcapitation payments or other payments in excess of amounts specified in the Contract;

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

(3) the process, timeframes, and documentation required for reporting the recovery of all

Overpayments; and

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

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

(C) The Contractor shall submit to the Department a quarterly report of Overpayments and recoveries within the timeframes specified by the Department. The report shall be in a Department specified format. The Contractor shall also submit the quarterly report to the Utah OIG (mpi@utah.gov) of Fraud, Waste, or Abuse-related Overpayments.

11.1.6 Recovery and Retention of Overpayments, Generally

The Contractor may collect and retain Overpayments from Providers. If Overpayments are related to Fraud, Waste, or Abuse, then 11.1.7 and 11.1.8 of this Article apply.

11.1.7 Collection and Retention of Overpayments Related to Fraud, Waste, or Abuse

The Contractor may collect and retain Overpayments it recovers during the Recovery Period.

11.1.8 Referral to the Utah OIG of Overpayments Related to Fraud, Waste, or Abuse

(A) When the 12 months of the Recovery Period have ended and the Contractor has not recovered any Overpayments from the Provider, or has ceased collecting Overpayments from the Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(B) If the Contractor has been collecting Overpayments from the Provider during the 12 months of the Recovery Period, the Contractor may continue to recover Overpayments from the Provider after the 12 months of the Recovery Period. If at any time after the twelfth month of the Recovery Period the Contractor determines it will be unable to continue collection, the Contractor shall refer the Overpayment to the Utah OIG. The Contractor shall retain any Overpayments it has recovered. The Utah OIG will retain its Overpayment recoveries.

(C) If the Contractor chooses not to pursue any Overpayment recoveries from a Provider, the Contractor shall refer the Overpayment to the Utah OIG. The Utah OIG will retain its Overpayment recoveries.

(D) If the Utah OIG identifies an unreported Overpayment, the Utah OIG will coordinate with the Contractor and may pursue collection of the Overpayment. The Utah OIG will retain its Overpayment recoveries.

(E) The Contractor shall correct Encounter Data related to Overpayments in accordance with Article 12.4.1.

11.1.9 Managed Care Activities that may be Vacated by the Court

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The Department must adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the Capitation Payment for that work should be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its Capitation Payments to the Contractor, the Contractor may keep the Capitation Payment for that work even if the payment was made after the date the program or activity lost legal authority.

11.2 Medicare

11.2.1 Payment of Medicare Part B Premiums

(A) The Department shall pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee shall assign to the Contractor his or her Medicare reimbursement for benefits received under Medicare.

(B) The Department shall identify on the Eligibility Transmission the Enrollees who are covered under Medicare.

11.2.2 Payment of Services Covered by Medicare

(A) The Contractor's payment for Medicare crossover claims shall be the allowed amount of Contractor's payment rate less any amounts paid by Medicare and other payors.

(B) When a service is paid for by Medicare, the Contractor shall pay in accordance with 12.2.2(A) of this Contract whether or not the service is covered under this Contract.

(C) The Contractor is responsible for payment whether or not the Medicare covered service is rendered by a Network Provider or has been authorized by the Contractor.

11.2.3 Prohibition on Balance Billing

The Contractor shall ensure its Network Providers will not balance bill the Enrollee. The reimbursement from Medicare and from the Contractor shall be payment in full.

11.2.4 Coordination of Benefits for Dual Eligibles

To the extent that 42 CFR 438.3(t) applies, the Contractor shall enter into a Coordination of Benefits Agreement with Medicare.

11.3 Third Party Liability and Coordination of Benefits

11.3.1 Recovery of Third Party Liability, Generally

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

11.3.2 Policies and Procedures for Third Party Liability Recovery

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

- (1) procedures and mechanisms to identify potentially liable Third Parties. Procedures and mechanisms shall include at a minimum, verification of any Third Party coverage at the time of service. When Enrollees obtain Covered Services from Providers not employed by the Contractor, the Contractor may delegate the Third Party verifications to Providers;
- (2) procedures and mechanisms to identify the amount owed by a Third Party;
- (3) procedures and mechanisms for recovery of Third Party Liability payments; and
- (4) procedures and mechanisms to report to the ORS any Third Party discrepancies identified within 30 working days of receipt of the 834 Benefit Enrollment and Maintenance File. The Contractor's report shall include a listing of Enrollees that the Contractor has independently identified as having another Third Party, including when an Enrollee's parent has an order of duty to provide medical support. The Contractor shall report changes to ORS either by email (TPLChanges@utah.gov) or by fax (801-536-8912).

11.3.3 Pay and Chase and Cost Avoidance

(A) The Contractor shall use reasonable efforts to evaluate the probable existence of TPL. Probable existence of TPL exists where:

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

(2) the Contractor or Provider has determined that the Third Party will likely cover the service.

(B) Except as otherwise provided in Article 11.2.3(C) of this Contract, if the Contractor has established the probable existence of TPL, the Contractor shall, if providing services directly, seek payment from the Third Party, or at the time a Provider files a Claim with the Contractor, the Contractor must reject the Claim and return it to the Provider for a determination of the amount of liability.

(1) The establishment of TPL takes place when the Contractor receives confirmation from the Provider or a third party resource indicating the extent of TPL.

(2) If the Provider or the Third Party gives reasonable evidence that the TPL was not in effect at the time of service or the service received by the Enrollee is not covered by the Third Party, the Contractor shall pay the Claim, to the extent that the service is a Covered Service.

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

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

(1) the claim is preventative pediatric services (including EPSDT services provided for under 42 CFR 441, Part B), and is covered under the State Plan;

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

(D) If the probable existence of TPL cannot be established or Third Party benefits are not available to pay the Enrollee's medical expenses at the time the Claim is filed, the Contractor must pay the full amount allowed under the Contractor's payment schedule.

(E) If the Contractor or Provider learns of the existence of a liable Third Party after the Contractor has provided a service or after a Provider's Claim is paid, or benefits become available from a Third Party after the Contractor has provided a service or has paid a Claim, the Contractor or Provider, as applicable, must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable Third Party or benefits become available. If the Provider obtains the payment from the Third Party, the Contractor shall recoup the payment from the Provider.

(F) The Contractor shall retain any payment it receives from TPL. Unless Article 11.2.3(E) applies, the Provider shall retain any payment it receives stemming from TPL.

(G) Recovery is not required when a Claim is \$100 or less or \$300 or less for cumulative Claims.

Contractor shall report TPL payments and cost avoided amounts in the Encounter Data and in the enrollment, cost, and utilization report submitted to the Department.

11.3.4 Third Party Liability and Access to Care

(A) The Contractor shall not require an Enrollee to obtain Covered Services from a Provider solely on the basis that the Provider accepts the Enrollee's TPL.

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

11.4 Personal Injury Cases

11.4.1 Notification of Personal Injury Case

(A) The Contractor shall be responsible to notify the Office of Recovery Services (ORS) of all potential personal injury cases.

(B) Once a month, the Contractor shall submit to ORS a file of claims which includes personal injury diagnosis codes. The file shall be in a format required by ORS.

11.4.2 Request for Assignment

(A) The Contractor may request from the Department an assignment of the Department's right of recovery for an Enrollee who has a claim against a third party for an injury, disease or disability if:

- (1) the Enrollee has not filed a claim or commenced an action for recovery or the Enrollee has not commenced an action pro se;
- (2) the Enrollee does not have Fee For Service Claims, PMHP Claims, or Claims from another Health Plan which would be included in the action for recovery; and
- (3) ORS has not already commenced an action for recovery.

(B) The Department may grant an assignment to the Contractor in accordance with 12.4.2(A) at its sole discretion. Any grant of an assignment shall be in writing. If the Department grants the assignment:

- (1) the Contractor shall be required to update the Department with the status of the Contractor's recovery efforts upon request of the Department;
- (2) the Contractor shall bear its own costs associated with the recovery;
- (3) the Contractor shall report any Third Party Liability Recoveries on the 837 File;

(4) the Contractor shall be responsible for conducting any defense associated with any challenge of the assignment as well as costs associated with such defense; and

(5) any amounts recovered by the Contractor shall be retained by the Contractor.

(C) In any action commenced by ORS to pursue recovery of medical costs pursuant to Utah Code Ann. §26-19-7, the amounts recovered by ORS shall be retained by the Department.

11.5 Contractor's Payment Responsibilities

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

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

(1) Emergency Services;

(2) court ordered services that are Covered Services defined in Attachment C and Attachment D;

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

(4) Covered Services which an Enrollee has obtained from a Non-Network Provider for purposes of utilizing the Enrollee's TPL.

11.5.2 Payment to Non-Network Providers

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

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

(2) the rate equal to the applicable Medicaid Fee For Service rate; or

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

11.5.3 Covered Services which are Not the Contractor's Responsibility

(A) The Contractor may not restrict an Enrollee's choice of Provider for family planning services and supplies. The Contractor is not responsible for payment when family planning services are obtained by an Enrollee from a Non-Network Provider.

(B) The Contractor shall not be required to provide, arrange for, or pay for Covered Services to Enrollees whose illness or injury results directly from a catastrophic occurrence or disaster, including, but not limited to earthquakes or acts of war. The effective date of excluding such

Covered Services shall be the date specified by the Federal Government or the State of Utah that a federal or state emergency exists or disaster has occurred.

(C) An Enrollee who is Indian may choose to seek Covered Services from an Indian Health Care Provider. The Contractor shall not be required to pay for Covered Services provided to Indian Enrollees who receive services provided by Indian Health Care Providers. Such services shall be paid by the Department.

11.5.4 Department Responsibility for Payment

Except as described in Attachment F or otherwise by this Contract, the Department shall not be required to pay for any Covered Services under Attachment C and Attachment D which the Enrollee receives from any source outside of the Contractor except for family planning services.

11.5.5 Covered Services Provided by the Utah Department of Health, Division of Family Health and Preparedness

(A) For Enrollees who qualify for special services offered by or through the Department of Health, Division of Family and Health Preparedness (“DFHP”), the Contractor agrees to reimburse DFHP at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee becomes a Medicaid Eligible Individual and selects the Contractor as its Health Plan.

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

(2) The services provided in the outpatient team evaluation and follow-up visit for which the Contractor shall reimburse DFHP are limited to the services that the Contractor is otherwise obligated to provide under this Contract.

(B) If the Contractor desires a more detailed agreement for additional services to be provided by or through DFHP for Children with Special Health Care Needs, the Contractor may subcontract with DFHP. The Contractor agrees that the subcontract with DFHP shall acknowledge and address the specific needs of DFHP as a government provider.

11.5.6 Administrative Fee for Immunizations

When an Enrollee under the age of 19 has third party coverage for immunizations, the Contractor shall pay the Provider the administrative fee for providing the immunization and not require the Provider to bill the third party. The Contractor may choose to pursue the third party for the administrative fee after the payment has been made to the Provider.

11.5.7 Payment for Services to Newborns

If a baby is born to an Enrollee, the Contractor is responsible for all inpatient facility and inpatient professional services for both the mother and the newborn Enrollee associated with the birth.

11.6 Enrollee Transition Between Managed Care Entities or Fee For Service

11.6.1 Plan Transitions, Inpatient Hospital Stays

(A) When an Enrollee is in an inpatient hospital setting and becomes enrolled in a different MCE or FFS any time prior to discharge from the hospital, the Contractor is financially responsible for the entire hospital stay including all services related to the hospital stay until discharged.

(B) The Contractor shall not be responsible for an inpatient hospital stay when a Medicaid Member is not an Enrollee at the time of admission to the hospital but becomes an Enrollee during the hospital stay. The MCE in which the Medicaid Member was enrolled at admission to the hospital is responsible for the entire hospital stay including all services related to the stay until the patient is discharged. If the Medicaid Member was in FFS at admission, the Department is responsible.

(C) The MCE in which the Medicaid Member is enrolled at the time of discharge from the hospital is financially responsible for services provided to the Enrollee during the remainder of the month of discharge from the hospital.

(D) If an Enrollee transitions to FFS during the hospital stay and is in FFS upon discharge, the Department is financially responsible for services provided to the Medicaid Member after discharge from the hospital until the Medicaid Member is enrolled in an MCE.

(E) When an Enrollee is in an inpatient hospital setting and becomes ineligible for Medicaid any time prior to discharge from the hospital, the Contractor is financially responsible for the inpatient hospital stay only for the period of eligibility.

(F) When an Enrollee in an inpatient hospital setting loses eligibility and then later becomes eligible retroactively for Medicaid, without a break in Medicaid coverage, then the Contractor is financially responsible for the inpatient hospital stay described in 11.6.1 (A).

11.6.2 Enrollee Transition, Home Health Services

(A) When Enrollees have been in FFS or have been enrolled in a different MCE and have been receiving home health services from an agency not contracting with the Contractor, the Contractor shall pay the Medicaid rate for services provided to an Enrollee by an out-of-network home health agency until:

- (1) the home health agency enrolls as a Network Provider; or
- (2) the Contractor provides an assessment and transitions the Enrollee to an in-network home health agency.

(B) The Contractor shall include the Enrollee in developing the plan of care to be provided by the Contractor's home health agency before the transition. The Contractor shall make reasonable efforts to address the Enrollee's concerns regarding Covered Services provided by the Contractor's home health agency before the new plan of care is implemented.

11.6.3 Enrollee Transition, Medical Equipment

(A) When the Contractor authorizes medical equipment for an Enrollee and the Enrollee subsequently enrolls in a different MCE or FFS, the Contractor is responsible for the payment of the equipment regardless of when the equipment is received, and until the authorization expires.

(B) When the Department authorizes medical equipment for an Enrollee and the Enrollee subsequently enrolls with the Contractor, the Department is responsible for payment of the equipment regardless of when the equipment is received, and until the authorization expires.

(C) Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual client and also includes any attachments to the equipment, replacements, or new equipment. Any attachments to the equipment, replacements, or new equipment are the responsibility of either the Health Plan (or the Department if the member was FFS) in which the member is enrolled at the time the equipment is ordered.

11.6.4 Contractor Acceptance of Pre-Enrollment Authorization

The Contractor shall honor existing FFS and other MCE authorizations and reimburse Providers for Covered Services after the Medicaid Member enrolls with the Contractor until the Contractor has evaluated if the service is Medically Necessary and agrees with the authorization, makes a different determination, or makes arrangements to have the services provided by a Network Provider.

11.6.5 Department Acceptance of Contractor's Authorization

For Covered Services other than inpatient, home health services, and medical equipment, if the Contractor has authorized a Covered Service and an Enrollee transitions to FFS prior to the delivery of such Covered Service, the Department shall honor the Contractor's authorization until the Department has evaluated the medical necessity of the service and agrees with the Contractor's authorization or has made a different determination.

11.6.6 Sharing of Enrollee Information between the Contractor, Fee for Service, and Other MCEs

When members transition between MCEs or FFS the relinquishing MCE or FFS shall submit, upon request of the new MCE, any Medicaid Member information about the transitioning member prior to the transition, including, but not limited to, whether the Medicaid Member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, receiving dialysis, has a chronic illness, or is receiving treatment for a behavioral health condition. Chronic illness includes, but is not limited to, diabetes, hemophilia, HIV, schizophrenia disorders, bipolar disorders, and major depressive disorder.

11.6.7 Organ Transplant Prior Authorization

The Contractor shall honor prior authorizations for organ transplantations and any other ongoing

services initiated by the Department while the Enrollee was covered under FFS until the Enrollee is evaluated by the Contractor and a new plan of care is established.

Article 12: Additional Recordkeeping and Reporting Requirements

12.1 Recordkeeping Requirements

12.1.1 Health Information Systems, General Requirements

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

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

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

12.1.2 Accuracy of Data

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

- (1) verifying the accuracy and timeliness of the reported data, including data from Network Providers the Contractor is compensating on the basis of subcapitation payments;
- (2) screening the data for completeness, logic, and consistency; and
- (3) collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts.

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

12.1.3 Medical Records

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

12.1.4 Document Retention Requirements for Awards

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

- (1) if any litigation, claim, financial management review or audit is started before the expiration of the 3 year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved and final action apply;
- (2) to records for real property and equipment acquired with Federal funds which shall be retained for three years after final disposition;
- (3) when records are transferred to or maintained by the HHS awarding agency, the three year retention is not applicable to the recipient; and
- (4) to indirect cost rate computations or proposals, cost allocation plans and any similar computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates).

12.1.5 Record Retention Requirements, Generally

(A) Unless otherwise specified by this Contract or by state or federal law, the Contractor shall keep all documents and reports required by this Contract for a period of 6 years. Such documents include, but are not limited to, the attestation forms required by Article 6.3.2, Contractor's policies and procedures, Contractor's member handbooks, and copies of reports required by the Department.

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

12.2 Additional Reporting Requirements

12.2.1 Independent Financial Audit(s)

The Contractor shall submit an audited financial report to the Department by November 1st of each year. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The financial report shall be in a format designated by the Department. The audit shall be conducted by an organization that has no internal ties to the Contractor.

12.2.2 Enrollment, Cost and Utilization Reports

(A) The Contractor shall submit an enrollment, cost and utilization report in an format designated by the Department.

(B) The Contractor shall submit the report to the Department two times per year, as follows:

- (1) May 1 for the preceding six month reporting period (July through December).
- (2) November 1 for the preceding 12 month reporting period (July through June).

(C) The Contractor may request, in writing, an extension of the due date up to 30 calendar days beyond the required due date. The Department shall approve or deny the extension request within seven calendar days of receiving the request.

12.2.3 Semi-Annual Reports

(A) The following semi-annual reports are due May 1 for the preceding six month reporting period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June):

- (1) the Grievance and Appeals reports required by Article 8.7.1 of this Contract; and
- (2) reports summarizing information on corrective actions taken on physicians who have been identified by the Contractor as exhibiting aberrant physician behavior.

12.2.4 Reporting of Abortions, Sterilizations, and Hysterectomies

(A) On November 1 of each year, the Contractor shall submit to the Department the following information:

(1) an Excel spreadsheet containing the following information for all abortions, hysterectomies, and sterilizations performed during the prior fiscal year:

- (i) client name
- (ii) Medicaid ID number
- (iii) procedure code
- (iv) date of service

(2) consent forms for all abortions performed during the prior fiscal year;

(3) consent forms for a sample of 10% of hysterectomies and sterilizations during the prior fiscal year; and

(4) the medical records for all abortions performed during the prior fiscal year.

(B) The Department shall evaluate the documentation requested under Article 12.2.4 and may require medical record submission. The Contractor agrees to provide the additional documentation to the Department in the timeframes required by the Department.

12.2.5 Provider Network Reports

The Contractor shall submit a monthly electronic file of its Network Provider network that meets

the Department’s provider file specifications and data element requirements to the Department.

12.2.6 Case Management Reports

The Contractor shall submit annual case management reports no later than November 1 of each year for the preceding fiscal year. The report shall be in a format designated by the Department.

12.2.7 Provider Statistical and Reimbursement Reporting

(A) In accordance with the Utah State Plan Attachment 4.19-B, page 1, incorporated into Utah Administrative R414-1-5, by reference, the Contractor shall provide, upon a Provider’s request, a Provider Statistical and Reimbursement (PS&R) report.

(B) The PS&R report shall include statistical data including total covered charges, units, and reimbursement (including outpatient supplemental payments) by fiscal period.

(C) The Contractor shall provide the report within 30 calndardays of the request.

12.2.8 Development of New Reports

The Department may request other reports deemed necessary to the Department to assess areas including, but not limited to, access and timeliness or quality of care. The Contractor agrees to submit any report requested by the Department within the timeframes specified by the Department.

12.2.9 Data Collection

(A) By July 1st of each year, the Contractor shall provide the following information to the Department, in a Department specified format:

- (1) the results of any Enrollee or Provider satisfaction survey conducted by the Contractor;
- (2) medical management committee reports and minutes; and
- (3) customer service performance summary data.

12.2.10 Hospital Reporting

In accordance with Utah Code §26-36b-204(5), the Contractor shall submit a report to the Department for the prior fiscal year, in a format designated by the Department.

12.2.11 Parties in Interest

(A) The Contractor shall report to the Department, and upon request, to the Secretary of the Department of Health and Human Services, the Inspector General of the Department of Health and Human Services, and the Comptroller General a descriptions of transactions between the Contractor and a party in interest as defined by Section 1318(b) of the Public Health Services Act, including the following transactions:

- (1) any sale or exchange, or leasing of any property between the Contractor and such a party;
- (2) any furnishing for consideration of goods, services, (including management services) or facilities between the Contractor and such party, but not including salaries paid to employees for services provided in the normal course of their employment; and
- (3) any lending of money or other extension of credit between the Contractor and such a party.

12.3 Encounter Data

12.3.1 Encounter Data, General Requirements

- (A) In accordance with Section 1903(m)(2)(A)(xi) of the Social Security Act, the Contractor agrees to maintain sufficient patient Encounter Data to identify the Provider who delivers Covered Services to Enrollees.
- (B) The Contractor shall transmit Encounter Data to the Department using the HIPAA Transaction Standards for Health Care Claim data found in 45 CFR 162.1101 and 162.1102.
- (C) The Contractor shall transmit and submit all Encounter Data to the Department in accordance with the X12 Standards for Electronic Data Interchange, Health Care Claim: 837 Institutional and Professional Guides as well as the Department's 837 Companion Guides for Institutional and Professional Encounters, as amended.
- (D) The Contractor shall submit Encounter Data within 45 calendar days of the service or Claim adjudication date. The Encounter Data shall represent all Encounter Claim types (medical and institutional) received and adjudicated by the Contractor.
- (1) If the Contractor is submitting an Encounter which was adjudicated by a Subcontractor, the Contractor shall submit the Encounter data within 45 calendar days of receipt from the Subcontractor.
- (E) If the Contractor fails to submit at least 95 percent of its Encounter Data within the timely submission standard in 12.3.1(D), the Department may require corrective action.
- (F) The Contractor shall submit Encounter Data for all services rendered to Enrollees under this Contract, including:
- (1) services for which the Contractor determined no liability exists;
 - (2) services for which the Contractor did not make any payment, including services provided under a Subcontract, capitation or special arrangement with another facility or program; and
 - (3) services for Enrollees who also have Medicare coverage, if a Claim was submitted to the Contractor.

(G) The Contractor shall submit corrections to all rejected Encounter Data within 45 calendar days of the date the Department sends notice that the Encounter is rejected.

(H) If the Contractor discovers that Encounter Data for services and/or costs of Excluded Providers have been included in the submitted Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter Data.

(I) The Department will edit Encounter Data in accordance with HIPPA standards and Department instructions. The Department shall reject Encounter Data that are incomplete or that include incorrect codes.

(J) The Department will notify the Contractor of the status of rejected Encounter Data by sending the Contractor a 999 Implementation Acknowledgement for Health Care Insurance or a TA1 Interchange acknowledgment regarding file acceptance. The Department shall send the Contractor a 277 Health Care Claim Status Response Transaction advising the Contractor of the status of the processed Claims. The Contractor shall be responsible for reviewing the 999, TA1, and 277 transactions and taking appropriate action when necessary.

12.3.2 Encounter Data Validation

(A) The Department will conduct quarterly Encounter Data validations. To perform each validation, the Department will send the Contractor an Encounter Data validation questionnaire, and an Encounter Data submission detail file comprised of all accepted Encounter Data for the specified quarter that may be used for rate setting.

(B) The Contractor shall respond to the Department's Encounter Data validation questionnaire within 14 calendar days from the date the Department sends the questionnaire and the Encounter Data submission detail file.

(C) If the Contractor fails to comply with the Encounter Data validation process, the Department may require corrective action.

12.3.3 Encounter Data for Rate Setting

The Department will use for rate setting only the Encounter Data received by the Department's deadline.

12.4 Disallowance of Claims

12.4.1 Procedures for Incorrectly Paid Claims

(A) The Contractor shall take reasonable action to collect any incorrectly paid claim from the Provider within 12 months of the date of discovery of the incorrectly paid claim. Incorrectly paid Claims can include but are not limited to claims which were duplicative, overpaid, or disallowed.

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

the notice of the disallowance of the incorrectly paid claim. The Contractor shall correct any Encounter Data for any incorrectly paid claim regardless of whether the Contractor is successful in collecting the payment from the Provider.

(C) Failure to properly reverse or adjust Encounter Data will result in sanctions allowed by Article 14.

(D) The Contractor shall make payment to a Provider for a Claim submitted more than 12 months after the date of service where:

(1) the Provider has submitted a Claim for the date of service within 12 months of the date of service;

(2) the Contractor has denied the Claim or retracted payment because it believed the Enrollee had TPL that should have paid on the Claim;

(3) the Provider can show, through EOBs or other sufficient evidence that the TPL was either not in effect or will not cover the billed service; and

(4) absent the coordination of benefits issues or the timely filing issues, the Claim is otherwise payable.

12.5 Medical Loss Ratio

12.5.1 Medical Loss Ratio, Generally

(A) The Contractor shall calculate and report to the Department a MLR consistent with the MLR standards described in Article 12.5.

(B) The Contractor shall create separate MLR data reports for the Legacy Medicaid Population eligibility groups and the Adult Expansion Population eligibility groups covered under the Contract unless the Department requires different reporting and a separate MLR calculation for specific populations.

12.5.2 Medical Loss Ratio, Calculations

(A) The MLR calculation in a MLR reporting year is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

(B) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(C) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

- (D) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.
- (E) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- (F) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of Claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
- (G) The Contractor shall ensure that prescription drug rebates are excluded from the amount of actual claims costs used to calculate an MLR, also referred to as “spread pricing”. When calculating an MLR, prescription drug rebates means any price concession or discount received by the managed care plan or its Pharmacy Benefit Manager, regardless of who pays the rebate or discount.
- (H) The MLR calculation should not include shared savings, profit sharing, etc. as a medical expense.

12.5.3 Medical Loss Ratio, Credibility Adjustment

- (A) The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.
- (B) The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department.
- (C) The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.
- (D) If the Contractor’s experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

12.5.4 Medical Loss Ratio, Reporting

- (A) The Contractor shall submit a MLR report to the Department that includes, for each MLR report: total incurred Claims, expenditures on quality improving activities, expenditures related to fraud prevention activities as defined in 42 CFR 438.8(e)(4), non-Claims costs, Premium revenue, taxes, licensing fees, regulatory fees, methodology(ies) for allocation of expenditures, any credibility adjustment applied, the calculated MLR, any remittance owed to the Department (if applicable), a comparison of the information reported with the audited financial report, a description of the aggregation method used to calculate total incurred Claims, and the number of member months.
- (B) The Contractor shall submit the MLR report in a Department specified format no later than December 31st of each year, unless an alternative date is agreed to by the Parties.
- (C) The Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180

calendar days of the end of the MLR reporting year or within 30 calendar days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(D) In any instance where the Department makes a retroactive change to the Capitation Payments for a MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall recalculate the MLR for all MLR reporting years affected by the change and submit a new MLR report meeting the applicable requirements.

(E) The Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

12.6 Data Submission and Certification

12.6.1 Data Submission

(A) The Contractor shall submit the following data to the Department which is subject to the certification requirements found in 12.6.2:

(1) Encounter Data in the form and manner described in 42 CFR 438.818 and this Contract;

(2) data on the basis of which the Department certifies the actuarial soundness of Capitation Rates to the Contractor under 42 CFR 438.4, including base data described in 42 CFR 438.5(c) that is generated by the Contractor;

(3) data on the basis of which the Department determines the compliance of the Contractor with the MLR requirement described in this Contract at 42 CFR 438.8;

(4) data on the basis of which the Department determines that the Contractor has made adequate provision against the risk of insolvency as required under this Contract and 42 CFR 438.116;

(5) documentation described in 42 CFR 438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the Provider network as set forth in 42 CFR 438.206;

(6) information on ownership and control described in this Contract, 42 CFR 455.104 and 42 CFR 438.230; and

(7) the annual report of Overpayment recoveries as required by 42 CFR 438.608(d)(3).

(B) The Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's obligations under 42 CFR Part 438 as required by the Department or the Secretary of Health and Human Services.

12.6.2 Data Certification

(A) The individual who submits data, documentation or information described in Article 12.6.1 to the Department shall provide a certification, concurrently with the submission, which attests, based on the individual's best information, knowledge and belief that the data, documentation and information are accurate, complete and truthful.

(B) The data, documentation, or information required by 12.6.1 shall be certified by:

- (1) the Contractor's Chief Executive Officer (CEO);
- (2) the Contractor's Chief Financial Officer (CFO); or
- (3) an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

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

(D) For the purpose of the certification of Encounter Data, the Contractor's electronic submission of Encounter Data to the Department ensures that the person certifying the Encounter Data attests to the completeness and truthfulness of the the data and documents based on the person's best knowledge, information and belief in accordance with 42 CFR 438.606.

Article 13: Compliance and Monitoring

13.1 Audits

13.1.1 Inspection and Audit of Financial Records

(A) The Department and the federal government may inspect and audit any books and/or records of the Contractor or it's Network Providers that pertain to:

- (1) the ability of the Contractor to bear the risk of potential financial losses, or
- (2) to services performed or determinations of amounts payable under the Contract, or
- (3) for any other audit allowed by state or federal law.

(B) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law any of the Contractor's records that may reasonably be requested to conduct the audit.

(C) The Contractor shall, in accordance with 45 CFR 74.48 (and except for contracts less than the simplified acquisition threshold), allow the Health and Human Services (HHS) awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

13.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other Enrollee data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the Utah OIG, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

13.1.3 Information to Determine Allowable Costs

(A) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the Medicaid program for "related party/home office" transactions, as defined by CMS Manual 15-1.

(B) The records described in Article 13.1.3(A) shall be made available in Salt Lake City, Utah or the Contractor shall pay the increased cost of auditing at an out-of-state location. The increased costs shall include round-trip travel and two days of lodging and per diem. Additional travel costs of the out-of-state audit shall be shared equally by the Contractor and the Department.

13.1.4 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, Fraud-related data, Abuse-related data, patient outcome data, and cost utilization data, which shall include patient profiles, exception reports, etc.

(B) The Contractor shall provide all data required by the Department, the federal government, independent quality review examiners, and other Utah state agencies allowed to conduct such audits.

13.2 Department and Contractor Quality Control

13.2.1 Quality Improvement Reports

(A) Annually, the Contractor shall submit to the Department the following documents:

- (1) the Contractor's quality improvement program description for the current State Fiscal

Year or calendar year,

(2) the Contractor's quality improvement work plan for the current State Fiscal Year or calendar year, and

(3) the Contractor's quality improvement work plan evaluation for the previous State Fiscal Year or calendar year.

(B) These reports shall be in a format developed by the Department and be signed by the Contractor.

(C) The reports listed in Article 13.2.1 shall be due on August 31 of each year.

13.3 Utah Office of the Inspector General

13.3.1 General Requirements

(A) The Contractor shall cooperate with the Utah OIG in any performance or financial audit Medicaid funds received by the Contractor as allowed by Utah Code Ann. §63J-4a-202(2).

(1) Records requested by the Utah OIG must be provided within 30 days in accordance with Utah Administrative Code R367-1-7.

(2) The Utah OIG shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of an evidence based review criteria process standard in accordance with Utah Administrative Code R367-1-7(3)(b).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. §63A-13-301.

(C) The Contractor and its employees shall cooperate with the Utah OIG with respect to an audit or investigation as required by Utah Code Ann. §§63A-13-302, 303.

(D) In accordance with Utah Code Ann. §63A-13-304, the Contractor and its employees shall not interfere with a Utah OIG audit or investigation.

(E) The Contractor shall comply with all subpoenas from the Utah OIG that are properly issued pursuant to Utah Code Ann. §63A-13-401.

(F) The Contractor shall allow the Utah OIG to conduct announced or unannounced site visits in accordance with 42 CFR 455.432.

Article 14: Corrective Action and Sanctions

14.1 Corrective Action Plans

14.1.1 Corrective Action Plans, Generally

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the

Department may impose a corrective action plan to cure the Contractor's non-compliance.

(B) At the Department's discretion, the corrective action plan may be developed by the Department or the Contractor.

14.1.2 Department-Issued Corrective Action Plan

(A) The Department may develop a corrective action plan which the Department shall provide to the Contractor, in writing.

(B) The Contractor agrees to comply with the terms of a Department-issued corrective action plan and to complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan. If the Contractor fails to satisfactorily complete the Department's corrective action plan, the Department may assess liquidated damages in accordance with Article 14.3 of this Contract.

(C) If the Contractor disagrees with the Department's corrective action plan, the Contractor may file a Request for an administrative hearing within 30 calendar days of receipt of the Department's corrective action plan.

14.1.3 Contractor Generated Corrective Action Plan

(A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.

(B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.

(C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 calendar days of receipt. In the event that the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised. The corrective action plan submitted by the Contractor shall be deemed approved by the Department if the Department fails to respond to the Contractor within 20 calendar days of receipt of the Contractor's corrective action plan.

(D) The Contractor agrees to comply with the terms of a Department approved corrective action plan and to complete all required actions within the required timeframes. If the Contractor fails to satisfactorily complete the Department's corrective Action Plan, the Department may assess liquidated damages in accordance with Article 14.3 of this Contract.

14.1.4 Notice of Non-Compliance

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and timeframe in which the Contractor's non-

compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 calendar days to cure its non-compliance. However, the Department may shorten the 30 calendar day time period in the event that a delay would endanger an Enrollee's health or the timeframe must be shortened in order for the Department and the Contractor to meet federal guidelines.

(B) If the Contractor fails to cure the non-compliance as ordered by the Department and within the timeframes designated by the Department, the Department may, at its discretion, impose any or all of the following sanctions:

- (1) suspension of the Contractor's Capitation Payment;
- (2) assessment of Liquidated Damages;
- (3) assessment of Civil Monetary Penalties; and/or
- (4) imposition of any other sanction allowed by federal and state law.

(C) The Department agrees that it shall not, for an individual event of the Contractor's non-compliance, impose both liquidated damages and the suspension of the Contractor's Capitation Payment. The Department may choose to either suspend the capitation payment or impose liquidated damages.

(D) The Department's imposition of any of the Sanctions described in 15.1.4(B) is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in 15.1.4(B) in no way limits additional remedies, at law or at equity, available to the Department due to the Contractor's Breach of this Contract.

(E) The Department may impose any additional sanctions on the Contractor provided for under state statutes or regulations to address non-compliance.

14.2 Capitation Payment Suspension

14.2.1 Capitation Payment Suspension, Generally

(A) In addition to other remedies allowed by law and unless specified otherwise, the Department may withhold Capitation Payments to the Contractor if the Contractor:

- (1) fails to comply with any provision of this Contract;
- (2) fails to provide the requested information within 30 calendar days from the date of a written request for information, or by a mutually agreed upon date by the Parties;
- (3) has an outstanding balance owed to the Department for any reason; or
- (4) fails to submit or comply with a corrective action plan within the timeframes required by the Department.

(B) The Department shall provide written notice before withholding payments ten calendar days prior to the suspension of Capitation Payments.

(C) When the Department rescinds withholding of Capitation Payments to a Contractor, it will, without notice, resume payments according to the regular payment cycle.

14.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 calendar days.

(B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments, the Contractor may request a State Fair Hearing within 30 calendar days of receipt of the Department's notice of intent to suspend the Capitation Payments. The Department may continue to withhold Capitation Payments through the duration of the administrative hearing, unless ordered by the hearing officer to release the Capitation Payments.

14.3 Liquidated Damages

14.3.1 Liquidated Damages, Generally

(A) If the Contractor fails to perform or does not perform in a timely manner provisions under this Contract, damages to the Department may result. The parties agree that the damages from breach of this Contract may be incapable or very difficult of accurate estimation.

(B) Should the Department chose to impose liquidated damages, the Parties agree that the following damages provisions represent a reasonable estimation of the damages that would be suffered by the Department due to the Contractor's failure to perform. Such damages to the Department would include additional costs of inspection and oversight incurred by the Department due to Contractor's non-performance or late performance of any provision of this Contract.

(C) At its discretion, the Department may withhold liquidated damages from the Department's Capitation Payment to the Contractor.

(D) If the Department chooses to impose liquidated damages, the Department shall provide the Contractor with written notice of its intent to impose liquidated damages.

(E) If the Contractor disagrees with the reason for the imposition of liquidated damages, the Contractor may request a State Fair Hearing within 30 calendar days of receipt of the Department's notice of intent to impose liquidated damages. The Department may impose liquidated damages through the duration of the State Fair Hearing unless the State Fair Hearing

officer orders that the imposition of liquidated damages should be discontinued throughout the State Fair Hearing process.

(F) Each category of liquidated damages found in Article 14.3.2 and Article 14.3.3 is exclusive, meaning that for any individual event of non-compliance by the Contractor the Department may only assert one category of liquidated damages. For example, if the Department imposes liquidated damages of \$500 per calendar day for failure to comply with a corrective action plan, it may not also impose for the same event liquidated damages of \$300 per calendar day for failure to submit documents to the Department. Furthermore, each imposition of liquidated damages must be based on actual failure of the Contractor to comply with the terms of this Contract, and no event of noncompliance may be extrapolated to other unsubstantiated claims of noncompliance.

(G) In no event will the Contractor's cumulative liability under Article 14.3 be more than \$1,000,000 per calendar year.

(H) The Department's ability to assess liquidated damages under this Section 14.3 is limited to the Contractor. In no event will liquidated damages under this Article 14.3 be assessed against the Contractor's parent company or any other affiliate of the Contractor.

(I) In no event may liquidated damages be retroactively assessed against the Contractor for failures to comply with the terms of this Contract that occurred more than one year prior to the discovery of the failures except in cases involving fraud, waste, and abuse.

14.3.2 Liquidated Damages, Per Day Amounts

(A) The Department may assess the following damages against the Contractor for each date beyond the deadline that the Contractor was required to take the following actions:

- (1) \$300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;
- (2) \$400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;
- (3) \$1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 12.3);
- (4) \$1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 12.3) or Post Adjudication History file (as required under Article 4.14.8);
- (5) \$2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the timeframes established under Attachment E.
- (6) \$500 per calendar day the Contractor fails to submit or comply with corrective action plan;

(7) \$500 per calendar day that the Contractor fails to provide audit access as required by Article 13.1;

(8) \$1,000 per calendar day for each day that the Contractor does not comply with the fraud and abuse provision found in Article 6 and such failure requires Department intervention;

(9) \$5,000 per calendar day that the contractor fails to maintain a complaint and appeal system as required by this Contract and such failure requires Department intervention;

(10) \$500 per calendar day for other violation of 42 CFR 438 which requires Department intervention or supervision.

14.3.3 Additional Liquidated Damages

(A) The Department may assess and impose the following liquidated damages against the Contractor:

(1) \$1,000 per each occurrence that the Contractor fails to properly credential a Network Provider as required by Article 5.3 of this Contract (including a failure to search the LEIE database, or has provider agreements that do not meet the requirements of Article 5.3) and such failure to credential requires Department intervention or supervision; and

(2) \$1,000 per each occurrence where the Contractor fails to provide an Enrollee access to Covered Services as required by this Contract and such failure requires Department intervention or supervision.

14.4 Sanctions Allowed by Federal Law

14.4.1 Reasons for Imposition of Intermediate Sanctions

(A) In accordance with 42 CFR 438.700, the Department may impose intermediate sanctions when the Department determines that the Contractor:

(1) fails substantially to provide Medically Necessary Covered services that the Contractor is required to provide, under law or under this Contract with the Department, to an Enrollee covered under this Contract;

(2) imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;

(3) acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a client, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future medical services;

(4) misrepresents or falsifies information that it furnishes to CMS or the Department;

(5) misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or Provider;

(6) fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210;

(7) has distributed directly or indirectly through any agent or independent contractor Marketing Materials that have not been approved by the Department or that contains false or materially misleading information;

(8) prohibits or restricts a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient for any of the reasons listed in 42 CFR 438.102(a)(1); or

(9) has violated any of the other applicable requirements of Section 1903(m) or Section 1932 of the Social Security Act and its implementing regulations.

(B) In the event that the Contractor fails to safeguard Enrollee Protected Health Information the Contractor shall be subject to sanctions imposed by CMS pursuant to HIPAA and HITECH.

14.4.2 Types of Intermediate Sanctions

(A) The Department may impose any or all of the following intermediate sanctions:

(1) civil monetary penalties in the amounts specified in 42 CFR 438.704;

(2) appointment of temporary management of the Contractor as provided in 42 CFR 438.706 and this Contract;

(3) granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;

(4) suspension of all new enrollment, including default enrollment, after the effective date of sanction; and

(5) suspension of payment for clients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(B) The Department may impose additional sanctions provided for under state statutes or rules to address noncompliance.

14.4.3 Notice of Sanction

(A) In accordance with 42 CFR 438.710, the Department shall provide the Contractor with timely written notice before imposing any of the intermediate sanctions specified in Article 14.4.2. The notice shall explain the basis and the nature of the sanction.

(B) The Contractor has 30 calendar days to provide a written response to the Department.

(C) If the Contractor disagrees with the imposition of any of the sanctions specified in Article 14.4.2, the Contractor may request a State Fair Hearing. The Department may continue to impose the sanction through the duration of the State Fair Hearing unless the hearing officer orders otherwise.

14.4.4 Discretionary Imposition of Temporary Management

(A) Pursuant to 42 CFR 438.706, the Department may impose temporary management of the administration of the Contractor's Medicaid operations only if it finds (through onsite survey, Enrollee or other complaints, financial status, or any other source) that:

- (1) there is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 CFR 438.700 or that is contrary to any requirements of Section 1903(m) and Section 1932 of the Social Security Act;
- (2) there is substantial risk to the Enrollee's health; or
- (3) the sanction is necessary to ensure the health of the Contractor's Enrollees while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the Contractor.

14.4.5 Required Imposition of Temporary Management

(A) In accordance with 42 CFR 438.706, the Department shall impose temporary management of the administration of the Contractor's Medicaid operations (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act.

(B) The Department shall grant Enrollees the right to terminate enrollment without cause and shall notify Enrollees of their right to terminate Enrollment.

14.4.6 Hearing on Temporary Management

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

14.4.7 Duration of Temporary Management

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

14.4.8 Sanctions Imposed by CMS: Denial of Payment

The Department may recommend that CMS deny payments to new Enrollees in accordance with 42 CFR 438.730.

Article 15: Termination of the Contract

15.1 Automatic and Without Cause Termination

15.1.1 Automatic Termination

This Contract shall automatically terminate on December 31, 2022.

15.1.2 Termination Without Cause

(A) The Contractor may terminate this Contract without cause by giving the Department written notice of termination at least 60 calendar days prior to the termination date. The termination notice must be on the first working day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 calendar days written notice.

15.1.3 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services and related administrative functions required by this Contract until midnight of the last calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or 30 calendar days following termination, whichever occurs first.

(B) Upon any termination of this Contract the Contractor shall promptly supply to the Department any information it requests regarding paid and unpaid Claims.

(C) If the Contractor one of its Network Providers, or other subcontractor becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor, the Network Provider, or the Subcontractor.

15.2 Termination of Contract With Cause

15.2.1 Termination of Contract With Cause, Generally

(A) In accordance with 42 CFR 438.708, the Department may terminate this Contract and enroll the Contractor's Enrollees in other MCOs or PCCMs or provide their Medicaid benefits through other options included in the State Plan, if the Department determines that the Contractor has failed to:

- (1) carry out the substantive terms of this Contract; or
- (2) meet the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act.

(B) The Department will exclude from participation any MCO that has prohibited relationships as defined in 42 CFR 1002.203.

15.2.2 Pre-Termination Hearing

(A) In accordance with 42 CFR 738.710, before terminating the Contract pursuant to Section 16.2.1 of this Contract, the Department must provide the Contractor with a pre-termination hearing. The Department shall:

- (1) give the Contractor written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;
- (2) after the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of the termination; and
- (3) for an affirming decision, give Enrollees notice of termination and information consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of the termination.

(B) In accordance with 42 CFR 438.722, after the Department notifies the Contractor that it intends to terminate the Contract, the Department may give Enrollees written notice of the Department's intent to terminate the Contract and may allow Enrollees to disenroll immediately, without cause.

15.2.3 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

15.3 Close Out Provisions

15.3.1 Close Out Provisions and Transition Plan

(A) Notwithstanding any provision found in Attachment A, in the event of termination of this Contract, the Contractor shall complete any and all duties required by this Contract.

(B) In the event of termination of this Contract, the Contractor shall work with the Department to create a transition plan that addresses its administrative duties and the transition of care for Enrollees. The Contractor's transition plan shall include but not be limited to:

- (1) providing written notification of the Contractor's termination to all Enrollees at least 60 calendar days prior to the termination date of the Contract unless otherwise directed by the Department;
- (2) processing and paying any Claims generated during the lifetime of this Contract including completing Appeals by both Providers and/or Enrollees and any monetary reconciliations;
- (3) providing the Department with complete and accurate Encounter Data for all Encounters generated during the lifetime of this Contract;

(4) providing the Department with reports as required by this Contract and any other ad-hoc reports required by the Department;

(5) complying with any audit requests; and

(6) orderly and reasonable transfer of care for Enrollees.

(C) With the exception of retroactive Capitation Payments, the Department shall cease enrollment of Medicaid Eligible Individuals and Capitation Payments for dates following the termination of this Contract.

(D) The Contractor shall not accept any payments from the Department after the termination of this Contract, unless payment is for the time period covered under this Contract. If the Contractor determines the Department has made a payment in error, the Contractor shall notify the Department in accordance with Article 11.1.5 (A).

(E) The Department may withhold any payments due under this Contract until the Department receives from the Contractor any written and properly executed documents as required by written instructions from the Department.

(F) Failure of the Contractor to comply with the provisions found in this Article 15.3 shall be deemed a breach of Contract and the Department may exercise any remedy available under this Contract or by operation of law. The Department shall give the Contractor notice of any activities not completed after termination and shall give the Contractor an opportunity to cure any breaches prior to declaring a breach of the Contract.

Article 16: Miscellaneous Provisions

16.1 Additional Provisions

16.1.1 Integration

This Contract and all attachments hereto, contain the entire agreement between the parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the parties hereto and conduct between the parties which precedes the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof. Notwithstanding Attachment A, General Provisions, Article III, item 27, if there is a conflict between this Attachment B, Special Provisions, and the Attachment A, General Provisions, then this Attachment B shall control.

16.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

16.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of federal and state law.

16.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

16.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

16.1.6 Continuation of Services During Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly Capitation Payments to the Contractor.

16.1.7 Surveys

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

16.1.8 Policy, Rules, and Regulations

(A) The Contractor shall be aware of, comply with, and be bound by the State Plan, the Department's policies and procedures in Provider Manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its Network Providers comply with the policies and procedures in effect at the time when services are rendered.

(B) The Contractor shall comply with all appropriate and applicable state and federal rules and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act.

16.1.9 Solvency Standards

(A) Unless exempt, the Contractor shall comply with 42 CFR 438.116(a), and provide assurances

satisfactory to the Department showing that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the Contractor's debts if the Contractor becomes insolvent.

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

16.1.10 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

(1) 16.1.11 CMS Approval of Contract

(2) (A) The Contractor understands and agrees that this Contract is subject to approval by CMS. The Contractor agrees to execute any amendment necessary to make this Contract compliant with any CMS requirements. The Contractor shall be responsible for repayment of any disallowances of FFP in the event the Contractor refuses to execute a contract amendment to bring the Contract into compliance with any CMS requirements.

(B) The Contractor shall not be responsible for any disallowance of FFP imposed by CMS prior to CMS formal approval of the contract and related capitated rates.

16.2 Data Security Provisions

16.2.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

16.2.2 Network Security

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

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to one of the following:

(1) those standards which the State of Utah applies to its own network as found at <http://www.dts.utah.gov>;

(2) current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) any industry accepted standards that is comparable to those described in 16.3.2(B)(1) or (2).

16.2.3 Data Security

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

(1) standards that are at least as good as or better than that maintained by the State of Utah found at <http://www.dts.utah.gov>;

(2) current standards set forth and maintained by the National Institute of Standards and Technology; or

(3) any industry accepted standards that is comparable to those described in 16.3.3(A)(1) or (2).

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

16.2.4 Data Transmission

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

16.2.5 Data Storage

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

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

16.2.6 Data Re-Use

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

16.2.7 Notification of Confidential Data Breach

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

16.2.8 Confidentiality, Data Security, Subcontractors

The Contractor shall extend the Duty of Confidentiality found in Article 16.3.1 and the Confidential Data requirements found in Articles 16.3 to all Subcontractors used by the Contractor.

16.2.9 Access to State of Utah Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to any database maintained by the State of Utah or by the Department to whom the Department has given access.

(B) The Contractor shall notify the Department within two working days when an employee or Subcontractor who has access to a database maintained by the Department or the State of Utah no longer requires access to the database.

(C) On a quarterly basis the Contractor shall provide to the Department a log of all employees who have access to a Department or State of Utah-maintained database, and in submitting that log to the Department, shall certify that the job duties of each employee named in the log requires that employee to have access to a Department or State of Utah-maintained database.

16.3 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.

Attachment C – Covered Services

Article 1: Covered Services, Limitations, & Exclusions

1.1 Special Provisions

1.1.1 Covered Services, Generally

(A) The Parties agree that the State Plan, the Department’s 1915(b) waivers, the section 1115 Primary Care Network demonstration waiver, and the Department’s provider manuals are the official listings of the specific services Medicaid covers. In the event of a conflict between the State Plan, the 1915(b) waivers, the section 1115 Primary Care Network demonstration waiver, or the Department’s Provider Manuals, the Department retains the right to determine whether the services are Covered Services under this Contract.

(B) The Contractor shall administer Covered Services in accordance with the Department’s provider manuals.

(C) The Department shall have the right to interpret the State Plan, the State’s 1915(b) waivers, the section 1115 Primary Care Network demonstration waiver, provider manuals, Medicaid Information Bulletins, and the Coverage and Reimbursement Code Look-up tool.

(D) The Contractor shall ensure that Covered Services are Medically Necessary Services and 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. The Contractor shall make the records available to the Department upon request.

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

(F) Medicaid services can only be limited through utilization criteria based on Medical Necessity.

1.1.2 Carved Out Services, Generally

(A) The Contractor shall cover all services and codes that Utah Medicaid covers under the State Plan, the Department’s 1915(b) waivers, and the section 1115 Primary Care Network demonstration waiver, except when the service is:

- (1) specifically listed in this Contract as being carved out of this Contract;
- (2) otherwise limited by this Contract; or
- (3) limited by service limitations found in the State Plan.

1.2 Carved Out Services

1.2.1 Carved Out Services

(A) The Contractor is not responsible to cover the following State Plan or waiver services:

- (1) dental services including orthodontics and anesthesia except as provided in Article 1.3.26;
- (2) ambulance transportation services;
- (3) care in a nursing facility, intermediate care facility, or a long term acute care hospital when the prognosis indicates that a stay longer than 30 days will be required;
- (4) Waiver Services:
 - (i) Home and Community–Based Waiver Services for Individuals 65 or Older
 - (ii) Home and Community–Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older
 - (iii) Community Supports Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions
 - (iv) Home and Community – Based Waiver Services for Individuals with Physical Disabilities
 - (v) Home and Community – Based Waiver Services - New Choices Waiver
 - (vi) Home and Community – Based Waiver Services for Technology Dependent, Medically Fragile Individuals
 - (vii) Autism Spectrum Disorder Waiver Services
- (7) Non-emergency transportation, except as specified in Attachment B, Article 4.10;
- (8) Services provided by an Indian Health Services (IHS), Tribal or Urban Indian Organization (UIO) facility;
- (9) Chiropractic services;
- (10) Services performed at the Utah State Hospital;
- (11) Services performed at the Utah State Developmental Center;
- (12) Pharmacy services, except as provided in Article 1.3.33.

1.2.2 Mental Health Evaluations Ordered by the Department of Workforce Services or the Department of Health

(A) Evaluations requested by a court or the Utah Department of Human Services, Division of

Child and Family Services, solely for the purpose of determining if a parent is able to parent and should therefore be granted custody or visitation rights are carved-out of this Contract.

(B) Evaluations or reevaluations requested by the Department of Workforce Services or the Department to determine disability related to Medicaid eligibility are carved-out of this Contract. Such services shall be paid by the Department.

1.3 Covered Services

1.3.1 Covered Services, General Requirements

This Attachment C lists broad categories of Covered Services.

1.3.2 Inpatient Hospital Services

Services furnished in a licensed, certified hospital are Covered Services.

1.3.3 Outpatient Hospital Services

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital are Covered Services.

1.3.4 Emergency Department Services

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

1.3.5 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are Covered Services.

1.3.6 General Preventative Services

Preventative services such as mammograms, Pap smears, and prostate exams are Covered Services.

1.3.7 Vision Care

(A) Services provided by licensed ophthalmologists, licensed optometrists, and opticians within their scope of practice are Covered Services.

(B) Covered Services for vision for Traditional Enrollees include, but are not limited to, the following:

- (1) eye examinations and care to identify and treat medical problems;

- (2) eye refractions, examinations;
- (3) laboratory work;
- (4) lenses;
- (5) eyeglass frames;
- (6) repair of frames;
- (7) repair or replacement of lenses; and
- (8) contact lenses (when Medically Necessary).

(C) Eyeglasses including frames, lenses and contacts are Covered Services for EPSDT Enrollees.

1.3.8 Laboratory and Radiology Services

(A) Professional and technical laboratory and X-ray services furnished by licensed and certified providers are Covered Services.

(B) All laboratory testing sites, including physician office labs, providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

(C) Those laboratories with certificates of waiver shall provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

1.3.9 Physical Therapy

(A) Treatment and services provided by a licensed physical therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Non-Traditional Enrollees are limited to a combination of 16 visits per calendar year for physical therapy and occupational therapy.

1.3.10 Occupational Therapy

(A) Treatment and services provided by a licensed occupational therapist are Covered Services.

(B) Treatment and services shall be authorized by a physician and include services prescribed by

a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist.

(C) Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-21.

(D) Occupational therapy services provided in the home are Covered Services for EPSDT Enrollees.

1.3.11 Speech and Hearing Services

(A) Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss are Covered Services for Enrollees Eligible for EPSDT.

(B) Speech and language services are Covered Services for Enrollees eligible for EPSDT. For Enrollees who are not eligible for EPSDT, speech and language services are not Covered Services unless provided as part of an acute inpatient hospital stay, as outpatient therapy in an acute hospital owned and operated by the acute hospital, or at a Federally Qualified Health Center.

(C) Audiology and hearing services including hearing aids and batteries are Covered Services for EPSDT Enrollees.

(D) Speech augmentative communication devices (SACDs) are a Covered Service for EPSDT Eligible Enrollees. SACDs are a Covered Service for Enrollees who are not eligible for EPSDT if the SACD(s) is Medically Necessary.

1.3.12 Podiatry Services

Services provided by a licensed podiatrist are Covered Services.

1.3.13 End Stage Renal Disease—Dialysis

Treatment of end stage renal dialysis for kidney failure is a Covered Service. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.3.14 Home Health Services

(A) Home health services are defined as part-time intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound are Covered Services. Home health services are based on a physician's order and plan of care.

(B) Home health care shall be rendered by a Medicare-certified home health agency.

(C) The Contractor agrees to comply with all federal regulations regarding surety bonds. The

Contractor agrees to contract with only Medicare-certified home health agencies who carry a surety bond if federal regulations regarding this requirement are reinstated. The Department agrees to notify the Contractor if such federal regulations are reinstated.

(D) Personal care services as defined in the Department's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

1.3.15 Hospice Services

(A) Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are Covered Services. EPSDT Enrollees may elect to receive both palliative and aggressive care.

(B) Hospice care shall be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR, or freestanding hospice facility, the Contractor is responsible for up to 30 days of hospice care.

1.3.16 Private Duty Nursing

(A) Services provided by licensed nurses for ventilator-dependent individuals in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home are Covered Services.

(B) Requests for continuous care shall be evaluated on a case by case basis and shall be approved by the Contractor.

1.3.17 Medical Supplies and Medical Equipment

(A) Medical supplies and medical equipment are Covered Services which include any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but shall be ordered by a physician.

(B) Durable medical equipment (DME) which are considered Covered Services, includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies shall be provided by a DME supplier that has a surety bond. Necessary supplies and equipment shall be reviewed for Medical Necessity and follow the criteria of Utah Administrative Code R414-70, with the exception of criteria concerning long term care since long term care services are Non-Covered Services under the Contract.

1.3.18 Abortions and Sterilizations

(A) Abortions are Covered Services only under the following conditions specified in the Federal Hyde Amendment:

- (1) if the pregnancy is the result of an act of rape or incest; or
- (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(B) Sterilizations are Covered Services to the extent permitted by Federal and State law.

(C) Both abortions and sterilizations shall meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements shall be met regardless of whether Medicaid is primary or secondary payer.

1.3.19 Inpatient Hospital Mental Health Services

(A) Inpatient hospital psychiatric services are Covered Services. Inpatient hospital psychiatric services are 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, the public safety, or one which has resulted in marked psychosocial dysfunction or grave mental disability of the patient. 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.

(B) Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

(C) The Contractor shall pay for psychiatric inpatient hospital Covered Services regardless of where the service was delivered in the acute inpatient hospital.

(D) The Contractor shall be responsible for inpatient Covered Services for Enrollees regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder/intellectually disability, an organic disorder or a substance use disorder.

(E) History and physical examinations and physician rounds conducted during an inpatient psychiatric admission are Covered Services.

(F) If the Contractor admits or authorizes an Enrollee for psychiatric inpatient hospital services the Contractor is responsible for payment of those services regardless of whether those services ancillary to the inpatient admission are Covered Services.

1.3.20 Outpatient Behavioral Health Services

(A) Outpatient behavioral health services as outlined in the Rehabilitative Mental Health and Substance Use Disorder Services are Covered Services and include:

- (1) psychiatric diagnostic interview examination;

- (2) mental health assessment by a non-mental health therapist;
 - (3) psychological testing;
 - (4) individual psychotherapy;
 - (5) group psychotherapy;
 - (6) family psychotherapy with Enrollee present;
 - (7) family psychotherapy without the Enrollee present;
 - (8) psychotherapy for crisis;
 - (9) substance use disorder residential treatment;
 - (10) mobile crisis outreach team (MCOT);
 - (11) assertive community treatment (ACT);
 - (12) individual therapeutic behavioral services;
 - (13) group therapeutic behavioral services;
 - (14) individual psychotherapy with medical evaluation and management services;
 - (15) substance use disorder treatment (SUD) in licensed SUD residential treatment program;
 - (16) pharmacologic management;
 - (17) individual skills training and development services;
 - (18) psychosocial rehabilitative services;
 - (19) peer support services;
 - (20) targeted case management services;
 - (21) electroconvulsive therapy (ECT), including any accompanying anesthesia and other related charges;
 - (22) general medical consultations, neurological examinations, and neuropsychological testing which are Medically Necessary for diagnosing a mental health or substance use disorder;
 - (23) psychiatric services rendered by a psychiatrist in the emergency room; and
- (B) Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) (Social

Detox). The Contractor is responsible for the payment of outpatient behavioral health Covered Services regardless of whether the Enrollee has a co-occurring diagnosis of a developmental disorder/intellectual disability, or an organic disorder.

(C) The Contractor must provide a 24 hour 7 days per week, crisis line services for behavioral health. The crisis line shall be in compliance with State Rule R523-17-10. The Contractor may provide this service through a Subcontractor.

1.3.21 Additional Services

The following additional services are Covered Services as defined in the Department's Rehabilitative Mental Health and Substance Use Disorder Services manual:

- (1) psychoeducational services;
- (2) personal services;
- (3) respite care; and
- (4) supportive living.

1.3.22 Organ Transplants

(A) The following transplantations are Covered Services for Traditional Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article 4.8. Medical costs for the donor are only covered if the donor is Medicaid eligible.

(B) The following transplantations are Covered Services for Non-Traditional Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, and lung unless amended under the provisions of Attachment B, Article 4.8. Medical costs for the donor are only covered if the donor is Medicaid eligible.

1.3.23 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, freestanding ambulatory surgical centers, and birthing centers.

1.3.24 Skilled Nursing Facility, Intermediate Care Facility and Long Term Acute Care Stays 30 Days or Less

(A) The Contractor shall provide care for Enrollees in skilled nursing facilities, intermediate care facilities, and long term acute care (LTAC) hospitals, when such care is a continuum of a medical plan and when the plan includes a prognosis of recovery and discharge within 30 days or less.

(B) When the prognosis of an Enrollee indicates that the stay shall be more than 30 days, the Contractor shall notify the Department and the facility of the prognosis determination and shall initiate disenrollment.

(C) Skilled nursing care is to be rendered in a facility which meets federal regulations of participation.

1.3.25 Family Planning Services

(A) Family planning services are Covered Services. Family planning services include disseminating information, counseling, and treatments relating to family planning services.

(B) Family planning services shall be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services shall be provided in concert with Utah law.

(C) Birth control services include information and instructions related to the following:

- (1) birth control pills;
- (2) Norplant (removal only);
- (3) Depo Provera;
- (4) IUDs;
- (5) barrier methods including diaphragms, male and female condoms, and cervical caps;
- (6) vasectomy or tubal ligations;
- (7) NuvaRing®; and
- (8) office calls, examinations, or counseling related to contraceptive devices.

(D) Family planning Covered Services for Non-Traditional Enrollees are the same as Traditional Enrollees family planning Covered Services except the following are not Covered Services:

- (1) Norplant;
- (2) infertility drugs;
- (3) in-vitro fertilization; and
- (4) genetic counseling.

1.3.26 Medical and Surgical Services of a Dentist

(A) Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

(B) Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under this Contract.

(C) The Contractor is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider shall refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the Contractor is responsible for coverage of the inpatient hospital stay.

(D) The Contractor is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

(E) The Contractor is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

(F) The Contractor is responsible for anesthesia associated with a Covered Service.

1.3.27 Diabetes Education

(A) The Contractor shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

- (1) has recently been diagnosed with diabetes;
- (2) is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan; or
- (3) is determined by the health care professional to require re-education or refresher training.

1.3.28 Human Immunodeficiency Virus (HIV) Prevention

The Contractor shall have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) shall be culturally and linguistically appropriate. All Enrollees shall be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

1.3.29 Services to EPSDT Enrollees

(A) The Contractor shall provide to EPSDT Enrollees preventive screening services and other

necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

(B) The Contractor is not responsible for providing home and community-based services available through Utah’s Home and Community-Based waiver programs.

(C) The Contractor shall provide the full EPSDT services to all eligible EPSDT Enrollees in accordance with the periodicity schedule as described in the Utah EPSDT Provider Manual.

(D) The Contractor agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the EPSDT periodicity schedules. These policies and procedures shall emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the EPSDT Enrollees.

(E) There is no co-pay specific to services for EPSDT Enrollees. Any copays for services to EPSDT Enrollees are based on the type of service and the place of service.

(F) Enrollees ages 19 and 20 are eligible for EPSDT and receive Traditional benefits.

1.3.30 Treatment for Substance Use

Medical detoxification provided in a hospital for substance use disorders is a Covered Service.

1.3.31 Dental Fluoride Varnish

Application of dental fluoride varnish for children birth through 4 years as part of a well-child (EPSDT) exam is a covered service.

1.3.32 Autism Services

Autism Services are Covered Services only to the extent as outlined in the Utah Autism Services Provider Manual.

1.3.33 Physician Administered Pharmacy

Physician administered drugs billed using a HCPCS codes are covered services.

Article 2: Cost Sharing

2.1 Cost Sharing Provisions

2.1.1 General Requirements

(A) The Contractor shall ensure that cost sharing (co-payments and co-insurance) required of Enrollees are consistent with the Department’s cost sharing payment rules and policies.

(B) The Contractor shall not charge cost sharing to Enrollees who have been determined by the Department to have met their out of pocket monthly maximum. Enrollees may request that their

cost sharing be reviewed by the Department to determine whether the Enrollee has met their out of pocket monthly maximum amount. The Contractor shall refer any Enrollee seeking such a determination to the Department’s Health Program Representatives.

2.1.2 Services with Cost Sharing

(A) Enrollees who have cost sharing requirements are responsible to pay co-payments for the following services:

- (1) non-emergency use of the emergency room;
- (2) inpatient hospital stays;
- (3) pharmacy;
- (4) physician, except as excluded in Article 2.1.3(A)(5);
- (5) podiatry;
- (6) outpatient hospital; and
- (7) ophthalmologists.

2.1.3 Services without Cost Sharing

(A) The following services are excluded from cost sharing requirements:

- (1) services and prescription drugs related to family planning;
- (2) immunizations;
- (3) preventive services;
- (4) laboratory services;
- (5) radiology services;
- (6) evaluation and management (E/M) services performed for the purpose of providing psychiatric medication management;
- (7) outpatient mental health services;
- (8) SUD outpatient services (ASAM level 1.0), ;
- (9) SUD intensive outpatient services (ASAM level 2.1);
- (10) SUD partial hospitalization services (ASAM level 2.5, Day Treatment);
- (11) SUD residential services (ASAM level 3.1-3.5);

- (12) some nursing home stays; and
- (13) dental, except emergency dental services.

2.1.4 Enrollees Exempt from Cost Sharing

(A) The following Enrollees are exempt from all cost sharing requirements:

- (1) American Indians;
- (2) Alaska Natives;
- (3) pregnant women;
- (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 standard payment allowance.

Attachment D – Quality and Performance

Article 1: Quality Assessment and Performance Improvement Program

1.1 Quality Assessment and Performance Improvement, Generally

(A) Pursuant to 42 CFR 438.330, the Contractor shall have an ongoing comprehensive Quality Assessment and Performance Improvement Program (QAPIP) for the services it furnishes to its Enrollees.

(B) The QAPIP shall include a policymaking body that oversees the QAPIP. A designated senior official shall be responsible for administration of the program. The QAPIP includes an interdisciplinary quality assessment and performance improvement committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body, and other functional areas of the organization.

(C) The Contractor agrees that CMS, in consultation with States and other stakeholders may specify performance measures and topics for Performance Improvement Projects (PIPs) that would be required for the Contractor to implement.

1.2 Basic Elements of QAPIPs

(A) At minimum, the Contractor shall establish and maintain a QAPIP that complies with the following requirements:

- (1) Conducts Performance Improvement Projects (PIPs) in accordance with Article 1.4;
- (2) Collects and submit performance measurement data in accordance with Article 1.5;
- (3) Has in effect mechanisms to detect both underutilization and overutilization of services;
- (4) Has in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs as defined by the Department in the quality strategy under 42 CFR 438.340; and
- (5) Has in effect a process for evaluating the impact and effectiveness of its QAPIP.

1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Articles 1.1 and 1.2.

(B) The Contractor shall submit its written QAPIP plan to the Department by April 1 of each year.

1.4 Performance Improvement Projects

(A) The Contractor shall have ongoing Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas, including any PIPs required by CMS or the Department.

(B) Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and include the following:

(1) measurement of performance using objective quality indicators;

(2) implementation of interventions to achieve improvement in the access to and quality of care;

(3) evaluation of effectiveness of the interventions based on the quality indicators in Article 1.4(B)(1); and

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

(C) Before implementing a new PIP, the Contractor shall submit the requested PIP topic to the Department for approval using a format specified by the Department.

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

(E) The Contractor agrees that the Department may, at its discretion, set up a timeframe and deadline for the Contractor to complete a PIP.

1.5 Performance Measurement

(A) Annually, the Contractor shall:

(1) measure and report to the Department its performance, using standard measures required by the Department and/or CMS;

(2) submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or

(3) perform a combination of the above activities.

(B) The Contractor shall compile and submit to the Office of Health Care Statistics (OHCS):

- (1) audited Healthcare Effectiveness Data and Information Set (HEDIS) for the preceding calendar year by July 1 of each year as set forth in Utah Administrative Code R428-13, et seq; and
- (2) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data to OHCS as set forth in Utah Administrative Code R428-12 et seq.

(C) Data calculations for HEDIS and CAHPS, and the results of standard measures, shall include all plan Enrollees.

Article 2: Quality Tracking and Monitoring

2.1 Quality Measures

(A) The Contractor shall report separately to the Department the quality measures specified in Article 2.3 by August 1st of each year, if the required measures were not reported with the HEDIS and CAHPS measures collected by OHCS.

(B) The Contractor agrees that the Department may amend the quality measures found in Article 2.3. The Department, when possible, shall consult with the Contractor prior to changing the reportable quality measures and, when possible, shall negotiate with the Contractor the effective date of any new quality measures.

(C) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

2.2 Quality Targeted Improvement Plan

(A) The Contractor shall develop and implement a written plan for each quality measure currently below the national average. The written plan shall be in the Department-specified form called the Quality Targeted Improvement Plan (QTIP).

(B) The Contractor shall submit its QTIP on date specified by the Department. The Department shall give the Contractor 60 days advance notice of the due date.

(C) The Contractor shall revise its QTIP (including targeted rates and implementation plan) upon request by the Department.

(D) The Contractor agrees that the Department may track, monitor trends, and publish the Contractor's quality measure targeted rates and performance rates.

2.3 Quality Measure Table

	Measure
HEDIS	Follow-up After Hospitalization for Mental Illness (HEDIS-FUH/ NQF 0576)
HOME	Readmission Rate
HOME	Provider Accessibility and Availability
HOME	Coordinated Services

2.4 Quality Measure Corrective Actions

In the event that the Contractor's quality measure performance is not at or above the national average as required by this Article, the Contractor may be subject to the corrective actions found in Article 14 of Attachment B.

Article 3: External Quality Review

3.1 External Quality Review, Generally

(A) Pursuant to 42 CFR Part 438, Subpart E, the Department shall arrange for External Quality Reviews (EQRs) to annually analyze and evaluate aggregated information on quality, timeliness, and access to Covered Services in accordance with 42 CFR 438.358(b)(1)(i) through 438.358(b)(1)(iv).

(B) The Contractor shall maintain, and make available to the External Quality Review Organization (EQRO), all clinical and administrative records for use in EQRs.

(C) The Contractor shall comply and work to implement the EQRO's corrective action plan requirements and act in good faith to implement other recommendations resulting from the analysis required in Article 3.1(A) of Attachment D.

(D) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

3.2 Contractor Staffing Requirements

(A) The Contractor shall designate an individual to serve as a liaison for the EQRs.

(B) The Contractor shall designate representatives, as needed, including but not limited to a quality improvement representative and a data representative to assist with EQRs.

3.3 Copies and On-Site Access

(A) The Contractor shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during an on-site review.

(B) Document copying costs are the responsibility of the Contractor.

(C) Enrollee information includes, but is not limited to, medical records, administrative data, encounter data, and claims data, maintained by the Contractor or its Network Providers.

(D) On-Site EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate workspace, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Contractor shall assign appropriate staff to assist during on-site EQRs.

(G) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

3.4 Timeframe for Providing Information

(A) The Contractor shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by the Department.

(B) The Contractor agrees that the Department shall review requests for extensions of these timeframes and that the Department shall approve or disapprove the request.

Article 4: Miscellaneous Quality Provisions

4.1 Accrediting

(A) The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity.

(B) If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide the Department a copy of its most recent accreditation review including;

- (1) accreditation status, survey type, and level (as applicable);

- (2) accreditation results including recommended actions or improvements, corrective action plans, and summaries of findings; and
- (3) expiration of the date of accreditation.

Attachment E - Payment Methodology

Article 1 Comprehensive Risk Based Contract

1.1 Contract Classification

- (A) This Contract is classified as a Comprehensive Risk Contract.
- (B) The Contractor shall provide all services required by this Contract and the Department shall pay Capitation Payments and any supplemental payments which shall be considered payment in full for all services covered under this Contract.
- (C) The Contractor incurs loss if the cost of furnishing the services exceeds the payments under the Contract.
- (D) The Contractor may retain all payments under this Contract.
- (E) Pursuant to 42 CFR 438.6(e) the Contractor may provide services to Enrollees that are in addition to those covered under the State Plan although, the cost of these services cannot be included when determining rates.
- (F) The Parties understand and agree that Capitation Rates may only be made by the Department and retained by the Contractor for Medicaid-Eligible Enrollees.
- (G) The Contractor shall report to the state within 60 calendar days when it has identified a capitation payment or other payments in excess of the amounts specified in this Contract.

Article 2 Payments

2.1 Payment Schedule

- (A) The Department shall pay the Contractor a monthly Capitation Rate for each Enrollee as determined by the Department's 820 Enrollment Report whether or not the Enrollee receives a Covered Service during that month.
- (B) The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, the Department reserves the right to amend the rates to reflect the change in funding. The Department shall notify the Contractor of any change in the Capitation Rates due to a loss of funding. When possible, the Department shall make reasonable efforts to notify the Contractor at least 30 days prior to the change in rates.
- (C) For the period of July 1, 2020 to June 30, 2021, the following Capitation Rate has been determined to be actuarially sound by an actuary who meets the qualifications and standards

established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board:

Rate Cell	Rate Cell Description	PMPM Capitation Rate
U	Non-Dual Eligible	\$1,212.02
T	Dual Eligible	\$637.18

2.2 Payments for Enrollees in an IMD

In accordance with 42 CFR 438.6(e), the Department may make a monthly Capitation Payment to the Contractor for an Enrollee aged 21-64 receiving inpatient treatment in an IMD so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and the length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.