

Utah CHIP Model Contract Managed Care Entity (MCE)

Effective: July 1, 2021 (SFY 2022)

Attachment A - Utah Department of Health General Provisions

Attachment B – Special Provisions

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Attachment A: UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

NON STANDARD PROCUREMENT (NON-RFP)

1. DEFINITIONS

- a. "Authorized Persons" means Contractor's employees, officers, partners, Subcontractors or other agents of Contractor who need to access State Data to enable Contractor to perform its responsibilities under Contract.
- b. "Contract" means this agreement between the Department and Contractor, including the Contract Signature Page(s) and all referenced attachments and documents incorporated by reference.
- c. "Contract Signature Page(s)" means the cover page(s) that the Department and Contractor sign.
- d. "Contractor" means the person who delivers the services or goods described in the Contract.
- e. "Custom Deliverable" means the Work Product that Contractor is required to deliver to Department under this Contract.
- f. "Department" means the Utah Department of Health.
- g. "Director" means the Executive Director of the Department or authorized representative.
- h. "Federal pass through money" means federal money received by a nonprofit corporation through a subaward or contract but does not include federal money received by a nonprofit corporation as payment for goods or services purchased by the Department.
- i. "Goods" means any deliverable that is not defined as a Service that Contractor is required to deliver under the Contract.
- j. "Local money" means money that is owned, held or administered by a political subdivision of the state that is derived from fee or tax revenues but does not include money received by a nonprofit corporation as payment for goods or services purchased from the nonprofit corporation or contributions or donations received by the political subdivision.
- k. "Originating funding entity" means an individual or entity which provided to the Department any or all funds payable under this Contract.
- l. "Pass through funding" means money appropriated to a state agency which includes ongoing or one-time money and is designated as general funds, dedicated credits, or any combination of state funding sources, that is intended to be passed through the state agency to a local government entity, private organization, including not-for-profit organizations or persons in the form of a loan or grant.
- m. "Person" means any governmental entity, business, individual, union, committee, club, other organization, or group of individuals.
- n. "Recipient entity" means a local government entity or private entity, including a nonprofit entity, which receives money by way of pass through funding from the Department.
- o. "Services" means the furnishing of labor, time, or effort by Contractor pursuant to this Contract. Services include, but are not limited to, all of the deliverable(s) (including supplies, equipment, or commodities) that result from Contractor performing the Services pursuant to this Contract. Services include those professional services identified in Section 63G-6a-103 of the Utah Procurement Code.
- p. "State" means the State of Utah, in its entirety, including its institutions, agencies, departments, divisions, authorities, instrumentalities, boards, commissions, elected or appointed officers, employees, agents, and authorized volunteers.

- q. "State Data" means all confidential information, non-public data, personal data, and protected health information that is created or in any way originating with the State whether such data or output is stored on the Department's hardware, Contractor's hardware, or exists in any system owned, maintained or otherwise controlled by the Department or by the Contractor. State Data includes any federal data that the Department controls or maintains, that is protected under federal laws, statutes, and regulations. The Department reserves the right to identify, during and after the Contract, additional reasonable types of categories of information that must be kept confidential under federal and state laws.
- r. "State money" means money that is owned, held or administered by a state agency and derived from state fee or tax revenues but does not include contributions or donations received by the state agency.
- s. "Subcontract" means a written agreement between Contractor and another party to fulfill the requirements of the Contract.
- t. "Subcontractor" means subcontractors or subconsultants at any tier that are under the direct or indirect control or responsibility of the Contractor, and includes all independent contractors, agents, employees, authorized resellers, or anyone else for whom the Contractor may be liable at any tier, including a person or entity that is, or will be, providing or performing an essential aspect of this Contract, including Contractor's manufacturers, distributors, and suppliers.
- u. "Uniform Guidance" means Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards for the specified federal awarding agency set forth in Title 2 of the Code of Federal Regulations.
- v. "Work Product" means every invention, modification, discovery, design, development, customization, configuration, improvement, process, software program, work of authorship, documentation, formula, datum, technique, know how, secret, or intellectual property right whatsoever or any interest therein (whether patentable or not patentable or registerable under copyright or similar statutes or subject to analogous protection) that is specifically made, conceived, discovered, or reduced to practice by Contractor or Contractor's Subcontractors (either alone or with others) pursuant to this Contract. Work Product shall be considered a work made for hire under federal, state, and local laws; and all interest and title shall be transferred to and owned by Department. Notwithstanding anything in the immediately preceding sentence to the contrary, Work Product does not include any Department intellectual property, Contractor's intellectual property (that it owned or licensed prior to this Contract) or Third Party intellectual property.

2. **EFFECTIVE DATE:** Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in the Contract.
3. **GOVERNING LAW AND VENUE:** This Contract shall be governed by the laws, rules, and regulations of the State of Utah. Any action or proceeding arising from the Contract shall be brought in a court of competent jurisdiction in the State of Utah. Venue shall be in Salt Lake City, in the Third Judicial District Court for Salt Lake County.
4. **AMENDMENTS:** The Contract may only be amended by mutual written agreement signed by both parties, which amendment will be attached to the Contract. Automatic renewals will not apply to the Contract, even if listed elsewhere in the Contract.
5. **CHANGES IN SCOPE:** Any changes in the scope of the Services to be performed under this Contract shall be in the form of a written amendment to this Contract, mutually agreed to and signed by both parties, specifying any such changes, fee adjustments, any adjustment in time of performance, or any other significant factors arising from the changes in the scope of Services.
6. **LAWS AND REGULATIONS:** At all times during the Contract, Contractor shall comply with all applicable federal and state constitutions, laws, rules, codes, orders, and regulations, including licensure and certification requirements. If the Contract is funded by federal funds, either in whole or in part, then any federal regulation related to the federal funding will supersede this Attachment A.
7. **CONFLICT OF INTEREST:** Contractor represents that none of its officers or employees are officers or employees of the Department or the State of Utah, unless written disclosure has been made to the Department.
8. **CONFLICT OF INTEREST WITH STATE EMPLOYEES:** Contractor agrees to comply and cooperate in good faith with all conflict of interest and ethic laws, including but not limited to, Section 63G-6a-2404, Utah Procurement Code.
9. **INDEPENDENT CONTRACTORS:** Contractor and Subcontractors, in the performance of the Contract, shall act in an independent capacity and not as officers or employees or agents of the Department or State.
10. **PROCUREMENT ETHICS:** Contractor understands that a person who is interested in any way in the sale of any supplies, services, construction, or insurance to the State of Utah is violating the law if the person gives or offers to give any compensation, gratuity, contribution, loan, reward, or any promise thereof to any person acting as a procurement officer on behalf of the State of Utah, or who in any official capacity participates in the procurement of such supplies, services, construction, or insurance, whether it is given for their own use or for the use or benefit of any other person or organization.
11. **REPORTING RECEIPT OF FEDERAL AND STATE FUNDS.**
 - 11.1. If Contractor is a nonprofit corporation and receives federal pass through money or state money, Contractor shall disclose to the Department, annually and in writing, whether it has received in the previous fiscal year or anticipates receiving any of the following amounts: (i) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money in the amount of \$750,000 or more; (ii) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money at least \$350,000 but less than \$750,000; or (iii) revenues or expenditures of federal pass through money, state money that is not payment for goods or services purchased from Contractor, and local money of at least \$100,000 but less than \$350,000.
 - 11.2. If Contractor is a recipient entity that, under the terms of the contract, is receiving pass through funding that was neither issued under a competitive award process, nor in accordance with a formula enacted in statute nor in accordance with a state program under parameters in statute or rule that guides the distribution of the pass through funding,

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

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

13. PAYMENT:

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

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

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

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

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

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

- 15. INSURANCE:** Contractor shall at all times during the term of the Contract, without interruption, carry and maintain commercial general liability insurance from an insurance company authorized to do business in the State of Utah. The limits of this insurance will be no less than one million dollars (\$1,000,000.00) per occurrence and three million dollars (\$3,000,000.00) aggregate. Contractor also agrees to maintain any other insurance policies required in any applicable Solicitation. Contractor shall provide proof of the general liability insurance policy and other required insurance policies to the Department within thirty (30) days of contract award. Contractor must add the State of Utah as an additional insured with notice of cancellation. Failure to provide proof of insurance as required will be deemed a material breach of the Contract. Contractor's failure to maintain this insurance requirement for the term of the Contract will be grounds for immediate termination of the Contract.
- 16. WORKERS' COMPENSATION INSURANCE:** Contractor shall maintain during the term of this Contract, workers' compensation insurance for all its employees as well as any Subcontractor employees related to this Contract. Workers' compensation insurance shall cover full liability under the workers' compensation laws of the jurisdiction in which the service is performed at the statutory limits required by said jurisdiction. Contractor acknowledges that within thirty (30) days of contract award, Contractor must submit proof of certificate of insurance that meets the above requirements.
- 17. SALES TAX EXEMPTION:** The Services under the Contract will be paid for from the Department's funds and used in the exercise of the Department's essential functions as a State of Utah entity. Upon request, the Department will provide Contractor with its sales tax exemption number. It is Contractor's responsibility to request the Department's sales tax exemption number. It is Contractor's sole responsibility to ascertain whether any tax deductions or benefits apply to any aspect of the Contract.
- 18. SUSPENSION OF WORK:** Should circumstances arise which would cause the Department to suspend Contractor's responsibilities under this Contract, but not terminate this Contract, this will be done by written notice. Contractor's responsibilities may be reinstated upon advance formal written notice from the Department.
- 19. INDEMNIFICATION:**
- 19.1.** If Contractor is a governmental entity, the parties mutually agree that each party assumes liability for the negligent and wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for the Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.
- 19.2.** If Contractor is a non-governmental entity, Contractor shall be fully liable for the actions of its agents, employees, officers, partners, and Subcontractors. Contractor shall fully indemnify, defend, and save harmless the Department and the State of Utah from all claims, losses, suits, actions, damages, and costs of every name and description arising out of Contractor's performance of the Contract caused by any intentional act or negligence of Contractor, its agents, employees, officers, partners, or Subcontractors, without limitation; provided, however, that Contractor shall not indemnify for that portion of any claim, loss, or damage arising hereunder due to the sole fault of the Department. Contractor is solely responsible for all payments owed to any Subcontractor arising from Contractor's performance under the contract and will hold the Department harmless from any such payments owed to the subcontractor.
- 19.3.** The parties agree that if there are any limitations of Contractor's liability, including a limitation of liability clause for anyone for whom Contractor is responsible, such limitations of liability will not apply to injuries to persons, including death, or to damages to property.
- 20. INDEMNIFICATION RELATING TO INTELLECTUAL PROPERTY:** Contractor shall indemnify and hold the Department and the State of Utah harmless from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities, and costs in any action or claim brought against the Department or the State of Utah for infringement of a third party's copyright, trademark, trade secret, or other proprietary right. The parties agree that if there are any limitations of Contractor's liability, such limitations of liability will not apply to this section.

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

22. TERMINATION AND DEFAULT:

- 22.1.** The Department may terminate the Contract without cause, upon thirty (30) days written notice to Contractor.
- 22.2.** The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for the Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate the contract upon thirty (30) days' notice to Contractor. If funding to the Department is reduced due to an order by the Legislature or the governor, or is required by federal or state law, the Department may terminate the Contract or proportionately reduce the services and goods due and the amount due from the Department upon thirty (30) days written notice to Contractor. If the specific funding source for the subject matter of the Contract is reduced, the Department may terminate the Contract or proportionately reduce the services and goods due and the amount due from the Department upon thirty (30) days written notice to Contractor.
- 22.3.** Each party may terminate the Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of the Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within ten (10) days of the notice. If the default is not cured within the ten (10) days, the party giving notice may terminate the Contract forty (40) days from the date of the initial notice of default or at a later date specified in the notice.
- 22.4.** The Department may terminate the contract if Contractor becomes debarred, insolvent, files for bankruptcy or reorganization proceedings, sells 30% or more of the company's assets or corporate stock, or gives notice of its inability to perform its obligations under the Contract.
- 22.5.** Upon termination of the Contract, all accounts and payments for services rendered to the date of termination shall be processed according to the financial arrangements set forth herein for approved services rendered to date of termination. If the Department terminates the Contract, Contractor shall stop all work as specified in the notice of termination. The Department shall not be liable for work or services performed beyond the termination date as specified in the notice of termination.
- 22.6.** In the event of such termination, Contractor shall be compensated for services properly performed under the Contract up to the effective date of the notice of termination. Contractor agrees that in the event of such termination for cause or without cause, Contractor's sole remedy and monetary recovery from the State is limited to full payment for all work properly performed as authorized under the Contract up to the date of termination as well as any reasonable monies owed as a result of Contractor having to terminate contracts necessarily and appropriately entered into by Contractor pursuant to the Contract. Contractor further acknowledges that in the event of such termination, all work product, which includes but is not limited to all manuals, forms, contracts, schedules, reports, and any and all documents produced by Contractor under the Contract up to the date of termination are the property of the State and shall be promptly delivered to the State.
- 22.7.** If the Department terminates the Contract, the Department may procure replacement goods or services upon terms and conditions necessary to replace Contractor's obligations. If the

termination is due to Contractor's failure to perform, and the Department procures replacement goods or services, Contractor agrees to pay the excess costs associated with obtaining the replacement goods or services.

- 22.8.** If Contractor terminates the Contract without cause, the Department may treat Contractor's action as a default under the Contract.
- 22.9.** If Contractor defaults in any manner in the performance of any obligation under the Contract, or if audit exceptions are identified, the Department may, at its option, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. Default and audit exceptions for which payment may be adjusted or withheld include disallowed expenditures of federal or state funds as a result of Contractor's failure to comply with federal regulations or state rules. In addition, the Department may withhold amounts due Contractor under the Contract, any other current contract between the Department and Contractor, or any future payments due Contractor to recover the funds. The Department shall notify Contractor of the Department's action in adjusting the amount of payment or withholding payment. The Contract is executory until such repayment is made.
- 22.10.** Any of the following events will constitute cause for the Department to declare Contractor in default of this Contract: (i) Contractor's non-performance of its contractual requirements and obligations under this Contract; or (ii) Contractor's material breach of any term or condition of this Contract. The Department may issue a written notice of default providing a ten (10) day period in which Contractor will have an opportunity to cure. Time allowed for cure will not diminish or eliminate Contractor's liability for damages. If the default remains after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: (i) exercise any remedy provided by law or equity; (ii) terminate this Contract; (iii) impose liquidated damages, if liquidated damages are listed in this Contract; (iv) debar/suspend Contractor from receiving future contracts from the Department or the State of Utah; or (v) demand a full refund of any payment that the Department has made to Contractor under this Contract for Goods that do not conform to this Contract.
- 22.11.** The rights and remedies of the Department enumerated in this article are in addition to any other rights or remedies provided in the Contract or available in law or equity.
- 23. REVIEWS:** The Department reserves the right to perform plan checks, plan reviews, other reviews, and/or comment upon the Goods and Services of Contractor. Such reviews do not waive the requirement of Contractor to meet all of the terms and conditions of the Contract.
- 24. PERFORMANCE EVALUATION:** The Department may conduct a performance evaluation of Contractor's Services, including Contractor's Subcontractors. Results of any evaluation may be made available to Contractor upon request.
- 25. PUBLIC INFORMATION:** Contractor agrees that the Contract, related purchase orders, related pricing documents, and invoices will be public documents and may be available for public and private distribution in accordance with the State of Utah's Government Records Access and Management Act (GRAMA). Contractor gives the Department and the State of Utah permission to make copies of the Contract, related sales orders, related pricing documents, and invoices in accordance with GRAMA. Except for sections identified in writing by Contractor and expressly approved by the State of Utah Division of Purchasing and General Services, Contractor also agrees that Contractor's Proposal to the Solicitation will be a public document, and copies may be given to the public as permitted under GRAMA. The Department and the State of Utah are not obligated to inform Contractor of any GRAMA requests for disclosure of the Contract, related purchase orders, related pricing documents, or invoices.
- 26. PUBLICITY:** Contractor shall submit to the Department for written approval all advertising and publicity matters relating to this Contract. It is within the Department's sole discretion whether to provide approval, which must be done in writing.

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

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

29. SECURE PROTECTION AND HANDLING OF STATE DATA:

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

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

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

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

discrepancy between a signed business associate agreement and this provision, the business associate agreement language shall take precedence.

30. OWNERSHIP, PROTECTION, AND RETURN OF DOCUMENTS AND DATA UPON CONTRACT

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

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

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

- 32.1.** Contractor has received payment for the Custom Deliverables,
- 32.2.** Each party will retain all rights to patents, utility models, mask works, copyrights, trademarks, trade secrets, and any other form of protection afforded by law to inventions, models, designs, technical information, and applications ("Intellectual Property Rights") that it owned or controlled prior to the effective date of this contract or that it develops or acquires from activities independent of the services performed under this contract ("Background IP"), and
- 32.3.** Contractor will retain all right, title, and interest in and to all Intellectual Property Rights in or related to the services, or tangible components thereof, including but not limited to (a) all know-how, intellectual property, methodologies, processes, technologies, algorithms, software, or development tools used in performing the Services (collectively, the "Utilities"), and (b) such ideas, concepts, know-how, processes, and reusable reports, designs, charts, plans, specifications, documentation, forms, templates, or output which are supplied or otherwise used by or on behalf of Contractor in the course of performing the Services or creating the Custom Deliverables, other than portions that specifically incorporate proprietary or Confidential Information or Custom Deliverables of Department (collectively, the "Residual IP"), even if embedded in the Custom Deliverables.
- 32.4.** Custom Deliverables, not including Contractor's Intellectual Property Rights, Background IP, and Residual IP, may not be marketed or distributed without written approval by Department.

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

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

34. WARRANTY OF GOODS:

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

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

- 34.3.** Contractor warrants and represents that all services shall be performed in conformity with the requirements of the Contract by qualified personnel in accordance with generally recognized standards and conform to contract requirements.
- 35. WARRANTY REMEDIES:** Contractor acknowledges that all warranties granted to the Department by the Uniform Commercial Code of the State of Utah apply to the Contract. Product liability disclaimers and/or warranty disclaimers from Contractor are not applicable to the Contract. For any goods or service that the Department determines does not conform with this warranty, the Department may arrange to have the item repaired or replaced, or the service performed either by Contractor or by a third party at the Department's option, at Contractor's expense. If any item or services does not conform to this warranty, Contractor shall refund the full amount of any payments made. Nothing in this warranty will be construed to limit any rights or remedies the Department may otherwise have under the contract.
- 36. UPDATES AND UPGRADES:** Contractor grants to the Department a non-exclusive, non-transferable license to use upgrades and updates provided by Contractor during the term of the Contract. Such upgrades and updates are subject to the terms of the Contract. The Department shall download, distribute, and install all updates as released by Contractor during the length of the Contract, and Contractor strongly suggests that the Department also downloads, distributes, and installs all upgrades as released by Contractor during the length of the Contract. Contractor shall use commercially reasonable efforts to provide the Department with work-around solutions or patches to reported software problems that may affect the Department's use of the software during the length of the Contract.
- 37. TECHNICAL SUPPORT AND MAINTENANCE:** If technical support and maintenance is a part of the Goods that Contractor provides under the Contract, Contractor will use commercially reasonable efforts to respond to the Department in a reasonable time when the Department makes technical support or maintenance requests regarding the Goods.
- 38. EQUIPMENT PURCHASE:** Contractor shall obtain prior written Department approval before purchasing any equipment, as defined in the Uniform Guidance, with contract funds.
- 39. DELIVERY:** Unless otherwise specified in the Contract, all deliveries will be F.O.B. destination with all transportation and handling charges paid by Contractor. Responsibility and liability for loss or damage will remain with Contractor until final inspection and acceptance, when responsibility will pass to the Department, except as to latent defects, fraud and Contractor's warranty obligations. The parties shall ship all orders promptly in accordance with the delivery schedule. Contractor shall submit promptly invoices (within thirty (30) days of shipment or delivery of services) to the Department. The parties shall list the state contract number on all invoices, freight tickets, and correspondence related to the Contract. The prices paid by the Department shall be the prices listed in the Contract, unless Contractor offers a prompt payment discount within its proposal or on its invoice. The Department has the right to adjust or return any invoice reflecting incorrect pricing.
- 40. ACCEPTANCE AND REJECTION:** The Department shall have thirty (30) days after the performance of the Services to perform an inspection of the Services to determine whether the Services conform to the standards specified in the Solicitation and this Contract prior to acceptance of the Services by the Department. If Contractor delivers nonconforming Services, the Department may, at its option and at Contractor's expense: (i) return the Services for a full refund; (ii) require Contractor to promptly correct or re-perform the nonconforming Services subject to the terms of this Contract; or (iii) obtain replacement Services from another source, subject to Contractor being responsible for any cover costs.
- 41. STANDARD OF CARE:** The Services of Contractor and its Subcontractors shall be performed in accordance with the standard of care exercised by licensed members of their respective professions having substantial experience providing similar services which similarities include the type, magnitude, and complexity of the Services that are the subject of this Contract. Contractor shall be liable to the Department and the State of Utah for claims, liabilities, additional burdens, penalties, damages, or

Attachment B – Special Provisions

Article 1: Introductory Provisions

1.1 Parties

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

(B) In compliance with 42 CFR 438.602(i), the Contractor agrees that for the duration of this Contract, the Contractor shall not be located outside of the United States and that no claims paid by the Contractor to a network provider, 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 that are permitted or required under this Contract, shall be in writing and shall be transmitted through 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:

SelectHealth Inc
5381 Green Street
Murray, UT 84130-0192

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

1.3 Service Area

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

Article 2: Definitions

2.1 Contract Definitions

2.1.1 Definitions

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

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

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.

Actuarially Sound Principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the populations and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

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

Adverse Benefit Determination means:

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

2. the 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, as defined as failure to meet performance standards for appointment waiting times;
5. the failure of the Contractor to act within the time frames 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 exercise the Enrollee's right to obtain services outside the network; or

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

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

Appeal means a request for review of an Adverse Benefit Determination taken by the Contractor.

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

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

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.

CAHPS means Consumer Assessment of Health Plans and Systems survey.

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

Capitation Payment means the payment the Department makes to the Contractor on behalf of each Enrollee for the provision of Covered Services. The Department makes the payment regardless of whether the particular Enrollee receives services during the period covered by the payment.

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

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.

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

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

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

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

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

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

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

1. outpatient hospital services;
2. rural health clinic services;
3. Federally Qualified health Center (FQHC) services;
4. other laboratory and X-ray services;
5. Nursing facility (NF) services;
6. Early and periodic screening, diagnostic, and treatments (EPSDT) services;
7. family planning services
8. physician services;
9. home health services.

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

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

Date of Discovery means on the date which identification by any Department official or other State official, the Federal Government, the provider of an Overpayment, or the Contractor and the 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 CHIP Provider (other than an individual practitioner or group of practitioners), or a Fiscal Agent. For purposes of the Contract, Disclosing Entity means the Contractor.

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.

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

Eligibility Transmission means the 834 Benefit Enrollment and Maintenance File.

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

1. placing the health of the individual (or, with respect to a pregnant Enrollee, the health of the Enrollee or their unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

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

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

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

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

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

Enrollment Area or Service Area means the counties enumerated in Article 1.4 of this Contract.

Excluded Parties List System or EPLS means the electronic version of the Lists of Parties Excluded from Federal Procurement and Non-procurement Programs (List) that identifies those individual and firms excluded from receiving Federal contracts or Federally-approved

subcontracts and from certain types of Federal financial and non-financial assistance and benefits. The EPLS website is located at <http://epls.gov>.

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

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

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

Family Member means all CHIP eligible individuals associated to same eligibility case number, included in the Eligibility Transmission who are members of the same family.

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

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

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

Federally Qualified 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 or 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.

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

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

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves 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.

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

Health Insurer Fee means the annual fee the Contractor is required to pay pursuant to Section 9010 of the Patient Protection and Affordable Care Act.

Health 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 federally defined Prepaid Ambulatory Health Plan, a federally defined Primary Care Case Management system, or a federally defined Managed Care Organization under contract with the Department to provide specified physical and behavioral health care services to a specific group of CHIP Eligible Individuals.

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

Indian means an individual, as defined by 25 U.S.C. §§1603(13c), 1603(28f), or 1679(ab) or who has been determined eligible, as in Indian, pursuant under 42 CFR §136.12

Indian Health Care Provider (IHCP) means a health care program, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization otherwise known as(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.

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

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

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

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

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

Marketing means any communication from the Contractor, its employees, Network Providers, agents or subcontractors to a potential enrollee that can reasonably be interpreted to influence the potential enrollee to enroll in Contractor's CHIP product, or either to not enroll in, or to disenroll from an another Health Plan's CHIP product.

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

Medicaid Fee for Service (FFS) means the delivery system or payment method for Medicaid members not enrolled in a Medicaid or CHIP managed care entity. Services are billed directly to and paid directly by Utah Medicaid.

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

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 member complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.

NCQA means the National Committee for Quality Assurance.

Network Provider means any provider, group of providers, or entity that has a network provider agreement with the Contractor, or a Subcontractor, and receives Medicaid or CHIP 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-Covered Service or **Non-Covered Item** means a medical service or item that is not a benefit to the Enrollee pursuant to this Contract, or is a medical service or item that does not meet Medical Necessity criteria for amount, duration, as described in the Utah State Plan.

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. This was formerly referred to as Non-Participating Provider

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 is 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.

NQF means the National Quality Forum.

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

OHCS means the Utah Department of Health's Office of Health Care Statistics.

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

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

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

Other Provider-Preventable Condition means a condition occurring in a health care setting that meets the following criteria:

1. Is identified in the State Plan.
2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
3. Has a negative consequence for the Enrollee.
4. Is auditable.
5. Includes, at minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Overpayment means any payment made to a Network Provider by a Managed Care Program to which the Network Provider is not entitled to under Title XXI 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 XXI 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 or **PIP** means a project designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on the health outcomes and Enrollee satisfaction.

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

1. Has an ownership interest totaling 5 percent or more in the Contractor;
2. Has an indirect ownership interest equal to 5 percent or more in the Contractor;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in the Contractor;

4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the property or assets of the Contractor;
5. Is an officer or director of the Contractor including the Contractor's Board of Directors' members, if applicable; or
6. Is a partner in the Contractor that is organized as a partnership.

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

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

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

Preauthorization means a service that must be approved by the Contractor before the service is rendered.

Premiums means quarterly amounts owed by CHIP Enrollees to the Department of Workforce Services. Premium amounts are different based on Federal Poverty Limit.

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

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

Prescription Drug Coverage means certain generic and name-brand drugs that are covered by Medicaid.

Prescription Drugs means generic and name-brand drugs that are prescribed by a doctor.

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

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

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

Provider means a Participating Provider or a Non-Participating Provider.

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

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

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.

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

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

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

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

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

plan approved under Title XXI of the Social Security Act.

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

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

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 all sections of this contract unless otherwise specified.

Suspended means Providers who have 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 or CHIP.

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

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

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

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 Contractor's Health Plan.

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

3.1.2 Prohibited Marketing Activities

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

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

3.2 Contractor Marketing Responsibilities

3.2.1 Policies and Procedures

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

3.2.5 Marketing Activities Prohibited

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

3.2.6 Outreach Activities, General Rules

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

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

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

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

3.3 Enrollment Process

3.3.1 Enrollee Choice

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

(B) The Department will inform Potential Enrollees of CHIP benefits.

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

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

3.3.2 Period of Enrollment

(A) Each Enrollee shall be enrolled for either the period of this Contract, the period of CHIP 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 Open Enrollment

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

3.3.4 Prohibition Against Conditions on Enrollment

(A) 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 CHIP 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.

3.3.6 CHIP and Medicaid Eligibility

- (A) If a CHIP Enrollee becomes eligible for Medicaid, CHIP coverage will end the last day of the month prior to the start of Medicaid eligibility.
- (B) The Contractor shall make a good faith effort to recover claims paid to a Provider after the date coverage began with Medicaid. The Contractor shall recover such claims according to industry standards. The Contractor shall use recovered claims to offset the total claims expenses.

3.3.7 CHIP and Other Health Insurance

- (A) If a CHIP Enrollee becomes eligible for private insurance during the same month or a month previously covered by CHIP, CHIP coverage will end the last day of the month in which ten (10) day proper notice of closure can be given.
- (B) The Contractor shall coordinate with the private insurance company to recover claims paid after the date coverage began with the private insurance. If the Contractor chooses to coordinate with the private insurance company, the Contractor shall pay as a secondary insurance. The Contractor shall not recover claims from the provider other than when coordinating with the private insurance company and paying as a secondary insurance plan. The Contractor shall use recovered claims to offset the total claims expenses. The Contractor shall not bill the CHIP Enrollee.

3.3.8 CHIP and Other Pharmacy Coverage

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

3.4 Eligibility Transmission

3.4.1 Eligibility Transmission, Generally

- (A) The Department shall provide to the Contractor a daily Eligibility Transmission which is an electronic file that includes data on individuals that the Department certifies as being CHIP eligible and who have been enrolled in 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 (UHN) 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, identification number, name, date of birth, date of death, social security number,

gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, (including those for American Indians) eligibility start date, Third Party Liability coverage, county, address, and phone number 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 XXI of the Social Security Act.

3.4.2 Eligibility File, Contractor Responsibilities

(A) The Contractor shall be responsible for ensuring that it is using the most recent 834 File when processing claims.

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

3.4.3 Enrollees in an Inpatient Hospital Setting

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

3.5 Member Orientation

3.5.1 Initial Contact, General Orientation

(A) The Contractor's representative shall ensure that each Enrollee's family or guardian receives the Contractor's Enrollee handbook within a reasonable time after the Contractor has been notified of the Enrollee's enrollment in the Contractor's Health Plan. The Contractor shall maintain written or electronic records of such initial contact.

(B) The Contractor's representative shall make a good faith effort to make an initial contact with the Enrollee within 10 working days after the Contractor has been notified through the Eligibility Transmission of the Enrollee's Enrollment in the Contractor's Health Plan. The Contractor shall maintain written or electronic records of such initial contact.

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

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

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

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

- (1) Specific written and oral instructions on the use of the Contractor's Covered Services and procedures;
- (2) Availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Non-Network Providers;
- (3) The rights and responsibilities of the Enrollee under the Contractor's Health Plan, including the right to file a Grievance or an Appeal and how to file a Grievance or an Appeal;
- (4) The right to terminate enrollment with the Health Plan;
- (5) Encouragement to make a medical appointment with a Provider; and
- (6) Encouragement to use well-child services and receive immunizations.

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

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

(A) The Contractor shall establish a policy which shall be used by Contractor's representatives during the initial contact to identify Enrollees with Special Health Care Needs.

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

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

(D) The Department's Health Program Representatives will forward information, including risk assessments, that identify Enrollees with Special Health Care Needs and limited language proficiency needs to the Contractor. Such information will coincide with the daily Eligibility Transmission whenever possible.

3.5.3 Identification Card

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

- (1) Children’s Health Insurance Program (CHIP);
- (2) Whether the Enrollee is, Plan B or Plan C, and if they are American Indian/Alaska Native. The Contractor will begin including the term American Indian/Alaska Native within 120 days of the start of the contract begin date.
- (3) The name of Contractor’s Health Plan;
- (4) A toll free Member Service number.

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

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

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

3.6 Enrollee Information

3.6.1 General Requirements

(A) The Contractor shall write all Enrollee and Potential Enrollee informational, instruction, and educational materials, in a manner that may be easily understood 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 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, including a description of applicable State law. The information on Advance Directives provided to adult Enrollees must reflect changes in State law as soon as possible but no later than 90 days after the effective date of the change.

(H) The Contractor shall use the terms as listed and defined in the Department-developed model handbook: 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-network provider; network provider; plan; physician services; preauthorization; premium; prescription drug coverage; prescription drugs; primary care provider; 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 Determining 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 begin using the model Enrollee handbook developed by the Department within a timeframe specified by the Department. The Department shall designate which sections 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.
- (3) regarding cost sharing on covered services provided by the Contractor.
- (4) which details that in the case of a counseling or referral service not covered by the Contractor 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;
- (5) on the amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled; and
- (6) 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;
- (7) on the extent to which, and how, after-hours care is provided;
- (8) on how emergency care is provided;
- (9) regarding what constitutes an Emergency Medical Condition;
- (10) regarding what constitutes an Emergency Service;
- (11) that prior authorization is not required for Emergency Services;
- (12) that the Enrollee has a right to use any hospital or other setting for emergency care;
- (13) that includes cost sharing for services furnished by the Contractor, if any is imposed under the State Plan;
- (14) on the Post-Stabilization Care Services rules set forth at 42 CFR 422.113(c);
- (15) on the Enrollee's freedom of choice among Network Providers;
- (16) on the extent to which, and how, Enrollees may obtain benefits including family planning services and supplies from Non-Network Providers;
- (17) that includes an explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning Provider;
- (18) that includes cost sharing for services furnished by the Contractor;
- (19) on Enrollee rights and responsibilities, including the Enrollee's right to:
 - (i) receive information on Enrollee and Contractor 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, as specified in Federal regulations on the use of restraints and seclusion; and
 - (vi) request and receive a copy of Enrollee's medical records and request that they be amended or corrected.
 - (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) that Enrollees may obtain Covered Services directly from an FQHC;
- (30) on how to exercise an Advance Directive;
- (31) how to access auxiliary aids and services, including additional information in alternative formats or languages at no cost;

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

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

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

3.6.6 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 information by email;

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

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

3.6.7 Network Provider Directory

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

(1) names and 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.

3.6.8 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.

3.6.9 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 working days after receiving the enrollee handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon time frame, the Contractor may deem such materials approved by the Department.

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

3.6.10 Publication of Covered Medications

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

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

3.6.11 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.

3.6.12 Additional Information to Enrollees

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

(B) The Contractor shall make a good faith effort to give written notice of termination of a Participating Provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received the Enrollee's primary care from, or was seen on a regular basis by, the terminated Participating Provider.

3.7 Disenrollment Initiated by Enrollees

3.7.1 Limited Disenrollment—Generally

Enrollees remain enrolled with the same Health Plan until they lose eligibility for CHIP or meet disenrollment criteria found in 3.7.2 or 3.7.3 below.

3.7.2 Limited Disenrollment—Without Cause

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

- (1) Within the first 90 days following the date of each enrollment period with the Health Plan;
- (2) During the open enrollment period (which shall occur at least once a year or as otherwise defined by the Department); or
- (3) When the Enrollee has been automatically re-enrolled after being disenrolled solely because the Enrollee lost CHIP eligibility for a period of two months or less and the temporary loss of CHIP eligibility caused the Enrollee to miss the annual disenrollment period.

3.7.3 Limited Disenrollment—With Cause

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

- (1) The Enrollee moves out of the Contractor's Service Area;
- (2) The Enrollee needs related services to be performed at the same time and not all services are available within the network, and the Enrollee's Primary Care Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
- (3) Other reasons as determined by the Department, including but not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of access to Providers experienced in dealing with the Enrollee's health care needs;
- (4) the Contractor does not, because of moral or religious objections cover the service the Enrollee seeks;
- (5) Enrollee becomes emancipated or is added to a different CHIP case; or
- (6) If the Contractor makes changes to its network of Network Providers that interferes with an Enrollee's continuity of care with the Enrollee's Provider of choice.

3.7.4 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 ten calendar days after receiving the disenrollment request, the disenrollment is considered approved.
- (E) The disenrollment shall be effective once the Department has been notified by the Enrollee, and the disenrollment is indicated on the Eligibility Transmission. The effective date of an approved disenrollment request shall be no later than the first day of the second month following the month in which the Enrollee filed the request.

3.8 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 their special needs (except when the Enrollee's continued enrollment in the Health Plan seriously impairs the Contractor's ability to furnish services to the 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) 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;
- (3) Upon termination or expiration of the Contract;
- (4) Death of the Enrollee;
- (5) Confinement of the Enrollee in an institution when confinement is not a Covered Service under the Contract;
- (6) Violation of enrollment requirements developed by the Contractor and approved by the Department but only after the Contractor and/or the Enrollee has exhausted the Contractor's applicable internal Grievance procedure; or

3.8.3 Approval by the Department Required

To initiate disenrollment of an Enrollee's participation with this 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 days of receipt of the request. If the Department does not respond to the disenrollment request within 30 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 30 days written notice of the proposed disenrollment, and shall notify the Enrollee of their opportunity to invoke the Contractor's Grievance process. The Contractor shall give a copy of the written notice to the Department at the time the notice is sent to the Enrollee.

3.8.5 Refusal of Re-Enrollment

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

3.8.6 Automatic Re-Enrollment

An Enrollee who is disenrolled from the Contractor's Health Plan solely due to loss of CHIP eligibility shall automatically be re-enrolled with the Contractor's Health Plan if the Enrollee regains CHIP 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 ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

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

(D) The Contractor may place limits on a service for the purpose of utilization control, provided:

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

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

(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.

4.2 Scope of Services

4.2.1 Scope of Covered Services

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

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

- (1) services that address the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
- (2) the ability for an Enrollee to achieve age-appropriate growth and development;
- (3) the ability for an Enrollee to attain, maintain, or regain functional capacity

4.2.2 Changes to Benefits

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

4.2.3 Court and Administrative Orders Regarding Benefits

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

4.3 Covered Services, Emergency Services

4.3.1 Emergency Services, Generally

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

(B) The Contractor shall cover and pay for Emergency Services, 24 hours a day 7 days a week, whether the servicing provider is a Network Provider or a Non-Network Provider regardless of the service area.

(C) The Contractor may not limit what constitutes an Emergency Medical Condition with reference to the definition of 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 ten calendar days of presentation for Emergency Services.

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

4.3.2 Payment Liability for Emergency Services

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

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

(C) If there is a disagreement between a Provider and the Contractor concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweighs the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one 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 shall 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 expect 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 Participating Provider or a Non-Participating Provider that are pre-approved by a Contractor representative.

4.4.3 Other Contractor-Liable Post-Stabilization Care Services

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

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

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

(2) The Contractor cannot be contacted; or

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

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

(ii) A Contractor physician resumes responsibility for the Enrollee's care;

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

(iv) The Enrollee is discharged.

4.4.4 Limitation on Charges to Enrollees

The Contractor shall 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, Maternity

4.5.1 Maternity Stays

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

- (1) inpatient care for a minimum of 48 hours of inpatient care following a normal vaginal delivery;
- (2) inpatient care for a minimum of 96 hours of inpatient care following a caesarean section; and
- (3) the Contractor shall not require the Provider attending the Enrollee and their newborn to obtain authorization from the Contractor in order to keep the Enrollee and their newborn in the inpatient setting for the periods of time described in Article 4.5.1 (A)(1) or (2).

(B) The Contractor shall not be required to provide coverage for post-delivery inpatient care for an Enrollee and their newborn during the periods described in Article 4.5.1(A)(1) or (2) if:

- (1) the attending Provider, in consultation with the Enrollee, discharges the Enrollee and the newborn prior to the expiration of the time periods described in Article 4.5.1(A)(1) or (2); and
- (2) the Contractor provides Timely Post-Delivery Follow-Up Care.

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

4.6 Diabetes Education

4.6.1 Contractor Provision of Diabetes Education

(A) Under orders of a Provider with prescribing authority, the Contractor shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

- (1) has recently been diagnosed with diabetes; or
- (2) is determined by the Provider to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan; or
- (3) is determined by the Provider to require re-education or refresher training.

4.7 Covered Services, Hospice

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

4.8 Covered Services, Enrollees with Special Health Care Needs

4.8.1 Identification of Enrollees with Special Health Care Needs

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

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

4.8.2 Primary Care Provider for Enrollees with Special Needs

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

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

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

4.8.3 Referrals and Access to Specialty Providers

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

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

4.8.4 Collaboration for Enrollees with Special Health Care Needs

(A) The Contractor shall share with other MCEs contracted with the Department who are serving Enrollees with Special Health Care Needs the results of its identification and assessment of each Enrollee's needs to prevent duplication of activities.

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

(C) The Contractor shall coordinate health care needs for Enrollees with Special Health Care Needs with the services of other agencies such as mental and substance abuse, public health departments, transportation, home and community based care, developmental disabilities, Title V, local schools, IDA programs, and child welfare, and with families, caregivers, and advocates.

4.9 Covered Services, Mental Health and Substance Use Disorders

4.9.1 Coordination of Mental Health and Substance Use Disorders (MH/SUD)

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

(B) In accordance with 42 CFR 438.236 (c) the Contractor is required to make available the criteria for medical necessity determinations made by the Contractor for mental health or substance abuse disorder benefits to any enrollee, potential enrollee, or Network Provider upon request.

4.9.2 Parity in Mental Health and Substance Use Disorder (MH/SUD) Benefits

(A) The Contractor shall provide documentation and reporting to demonstrate compliance with 42 CFR 457.1201(1) and 42 CFR 457.496 regarding parity in MH/SUD benefits in accordance with section 13.2.8 of the contract.

(B) The Contractor shall comply with parity requirements for aggregate lifetime and annual dollar limits in accordance with 42 CFR 457.496(C)

(C) The Contractor shall not apply any financial requirement or treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to medical/surgical benefits in the same classification. [42 CFR 457.1201(1); 42 CFR 457.496(d)(2)(ii)].

(D) The Contractor shall provide and Enrollee MH/SUD benefits in any classification of benefits

in which medical/surgical benefits are provided [42 CFR 457.1201(1); 42 CFR 457.496(d)(3)(iii)].

(E) The Contractor shall not apply any cumulative financial requirements for MH/SUD benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification [42 CFR 457.1201(1); 42 CFR 457.496(d)(3)(iii)].

(F) The Contractor shall follow the Non-Quantitative Treatment Limitations (NQTL) policy as specified in 42 CFR 457.1201(1) and 42 CFR 457.496(d)(4).

Article 5: Delivery Network

5.1 Availability of Services

5.1.1 Network Requirements

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

- (1) The anticipated enrollment;
- (2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the Contractor's Service Area;
- (3) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the contracted services;
- (4) The number of Network Providers who are not accepting new patients; and
- (5) The geographic location of Network Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities; and
- (6) Demonstrates that it's network includes sufficient family planning providers to ensure timely access to covered services.

(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, 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 Wasatch Front Urban areas of the State. Wasatch Front Urban, Rural and Frontier areas of Utah are listed in the following table.

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

		Wayne
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(B) The Contractor shall ensure that members have access to the following types of providers within the time and distance standards.

Time and Distance Standards			
Provider or facility type	Wasatch Front Urban Counties	Non Wasatch Front Rural Counties	Non Wasatch Front Frontier Counties
Primary Care – Pediatric	95% of members must have access within 10 miles or 20 minutes	85% of members must have access within 20 miles or 30 minutes	75% of members must have access within 30 miles or 60 minutes
OB/GYN	95% of members must have access within 10 miles or 20 minutes	85% of members must have access within 40 miles or 75 minutes	75% of members must have access within 60 miles or 90 minutes
Specialist	95% of members must have access within 10 miles or 20 minutes	85% of members must have access within 40 miles or 75 minutes	75% of members must have access within 60 miles or 90 minutes
Hospital	95% of members must have access within 10 miles or 20 minutes	85% of members must have access within 40 miles	75% of members must have access within 60 miles or 90 minutes

		or 75 minutes	
Pharmacy	95% of members must have access within 10 miles or 20 minutes	85% of members must have access within 20 miles or 30 minutes	75% of members must have access within 30 miles or 60 minutes
Behavioral health (mental health and substance use disorder)	90% of members must have access within 10 miles or 20 minutes	80% of members must have access within 20 miles or 30 minutes	75% of members must have access within 30 miles or 60 minutes

(C) 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
- (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.

(C) The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to Non-Network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, and standards used in determining access to Non-Network providers for medical/surgical benefits in the same classification.

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 that its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or are comparable to FFS enrollees, if the Network Provider serves only Medicaid enrollees.

(C) The Contractor shall make shall make all Covered Services are 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, and shall monitor its Network Providers regularly to determine compliance by Network Providers. If there is failure to comply, the Contractor shall take corrective action against the Network Provider.

5.2 Subcontracts and Agreements with Providers

5.2.1 Subcontracts, Generally

(A) The Contractor shall maintain the ultimate responsibility for adhering to and otherwise fully

complying with all terms and conditions of this Contract, notwithstanding any relationship(s) that the Contractor may have with any Subcontractor.

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

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

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

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

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

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

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

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

5.2.2 Agreements with Providers and Subcontractors

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

(1) Enrollee Grievance, Appeal, and State Fair Hearing procedures and

timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424;

(2) 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;

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

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

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

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

(E) The Contractor shall ensure its Network Providers are either enrolled with the Department as a Medicaid Fee-for-Service provider or are enrolled with the Department as a "Managed Care Only provider."

5.3 Contractor's Selection of Network Providers

5.3.1 Provider Enrollment with the Department

(A) The Contractor shall only make payments to Providers who are enrolled with the Department as a full or limited Provider, with the following exceptions:

- (1) Non-network providers under single case agreements;
- (2) Non-network providers who have provided and billed for emergency services; or
- (3) Network providers pending enrollment with the Department, per 438.602 (b)(2).

(B) The Contractor shall notify the Department, in a Department specified format, of network providers meeting an exception, per 5.3.1 (A) above, to ensure acceptance of encounters.

(C) The Contractor shall terminate a network provider immediately upon notification from the Department that the network provider cannot be enrolled or failed to enroll timely, per 438.602 (b)(2).

(D) Upon notification of termination from the Department, the Contractor shall notify affected enrollees in accordance with Section 3.6.7, Termination of Contracted Provider.

5.3.2 Network Provider Selection, Generally

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

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

5.3.3 Credentialing and Re-Credentialing Policies and Procedures

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

- (1) Network Provider completion of Contractor written applications;
- (2) Procedures for assuring that potential and current Network Providers are appropriately credentialed, (for example, that the Provider has a current license and/or accreditation as applicable and is in good standing with the licensing board and/or accreditation as applicable);
- (3) Primary source verification of licensure and disciplinary status by the State of Utah and other States;
- (4) Procedures for viewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension, or exclusion.

5.3.4 Timeframe for Re-Credentialing

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

- (1) Is completed at least every three years; and
- (2) Updates information obtained during the initial credentialing process.

5.3.5 Notifications

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

5.3.6 Documentation

The Contractor shall maintain documentation of its credentialing and re-credentialing activities. Upon request from the Department, the Contractor shall demonstrate that its Network Providers are credentialed and re-credentialed following Contractor's written credentialing and re-credentialing policies and procedures, 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 Participating Provider status. Such denial can include when a Provider is denied admission to the Contractor's provider panel, is removed from the Contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of the Department of Occupational and Professional Licensing's regulations, and allegations of Fraud, Waste or Abuse.

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

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

5.3.8 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

The Contractor shall enter into a subcontract with at least one Federally Qualified Health Center. The Contractor shall reimburse the FQHC an amount not less than what the Contractor pays comparable Providers that are not FQHCs.

5.3.10 Primary Children's Medical Center

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

5.3.11 Network Provider Hospital Reporting Requirements

(A) The Contractor shall submit to the Department by May 1 of each year, a list of hospitals with which the Contractor has entered into a Participating Provider agreement. The Contractor

shall state on this list any restrictions or limitations to clients receiving all Covered Services at any of the hospitals on the list.

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

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

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

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

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

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

(iii) the date of discharge if the Enrollee was admitted prior to Article 5.3.7(B)(1)(i) or (ii); and

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

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

5.3.12 Network Provider Practice Guidelines, General Standards

(A) The Contractor and its Network Providers shall develop or adopt practice guidelines consistent with current standards of care as recommended by professional groups such as the American Academy of Pediatrics and the U.S. Preventive Services Task Force. The practice guidelines shall meet the following requirements:

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

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

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

- (4) Guidelines shall be reviewed and updated periodically as appropriate.
- (B) The Contractor shall disseminate the practice guidelines to all affected Network Providers and, upon request, to Enrollees 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 Participating Provider have established an alternative payment schedule.
- (B) The Contractor shall pay 90 percent of all Clean Claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt.
- (C) The Contractor shall pay 99 percent of all Clean Claims from practitioners, who are in individual or group practice or who practice in shared facilities, within 90 days of the date of receipt.
- (D) The date of receipt is the date the Contractor receives the claim as indicated by its date stamp on the claim.
- (E) The date of payment is the date of the check or other form of payment.

5.4.2 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 Coverage Start Dates

- (A) The Contractor is responsible for making payment on claims for Enrollees upon enrollment with the Contractor.

5.4.4 Federally Qualified Health Center and Rural Health Clinic Payments

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

5.4.5 Division of Community and Family Health Services Payments

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

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

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

5.4.6 Network Requirements for Indians, Indian Health Care Providers (IHCP’s) and Indian Managed Care Entities (IMCE’s)

(A) The Contractor shall be able to demonstrate that there are sufficient IHCP’s participating in the Provider Network to ensure timely access to services available under the contract form such providers for Indian enrollees who are eligible to receive services.

(B) If an IHCP is a Network Provider and a Primary Care Provider, the Contractor shall allow Indian Enrollees to choose the Indian health care Provider as the Indian Enrollee’s Primary Care Provider.

(C) In accordance with 42 CFR 457.1209; 42 CFR 438.14(b)(2)(i) - (ii), the Contractor shall pay an IHCP, whether a Network Provider or not, for covered services provided to Indian enrollees, who are eligible to receive services at a negotiated rate between the Contractor and the IHCP or, in the absence of a negotiated rate, at the rate not less than the level and amount of payment the Contractor would make for the services to a participating provider that is not an IHCP.

(D) The Contractor shall permit Indian Enrollees to obtain Covered Services from an IHCP in accordance with 42 CFR 457.1209; 42 CFR 438.14(b)(4).

(E) The Contractor shall permit a Non-Network IHCP to refer an Indian Enrollee to a Network Provider in accordance with 42 CFR 457.1209; 42 CFR 438.14(b)(6).

5.4.7 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 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, XVII, 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.

(C) If the Contractor suspends payment pursuant to Article 5.6.1(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 shall 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 Title 42 of the Code of Federal Regulations, 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 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 program, that are designed to detect and prevent Fraud, Waste, and Abuse on the part of the Providers, Enrollees, and other patients who falsely present themselves as being CHIP eligible.

(B) The Contractor or Subcontractor 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 Departments 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 plan shall designate the staff members and other resources being allocated to the prevention, detection, investigation and referral of suspected Provider Fraud, Waste, and Abuse.

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

(F) The Contractor shall cooperate and coordinate with the Department, the Utah Office of Inspector General of Medicaid Services (Utah OIG), and the Medicaid Fraud Control Unit ("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 management arrangements or procedures and compliance plan to guard

against Fraud, Waste, and Abuse shall include the following:

- (1) Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State requirements;
- (2) The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract, and who reports directly to the Chief Executive Office and the board of directors;
- (3) A Regulatory Compliance Committee (RCC) accountable to senior management level charged with overseeing the organization's compliance plan and its compliance with the requirements under the Contract;
- (4) A system for effective training and education for the compliance officer, the Contractor's senior management and the Contractor's employees on the Federal and State standard 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) As detailed in Article 6.1.6 provisions for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees and the application of such verification processes on a regular basis;
- (9) Provisions for prompt reporting to the Department of all overpayments identified or recovered, specifying the overpayments, and adjusting encounters.
- (10) A provision for prompt notification to the Department when it receives information about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility including changes in the Enrollee's residence or the 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, provisions 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, a 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.

(15) A provision for notification to the Department within 60 calendar days when the Contractor has identified the capitation payments or other payments in excess of amounts specified in the contract.

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.
- (3) the names of Providers against which the Contractor has taken any adverse action for Fraud, Waste or Abuse, and a description of the adverse action taken.

6.1.4 Reporting Recipient-Related Fraud, Waste, and Abuse

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

6.1.5 Obligation to Suspend Payments to Providers

- (A) The Contractor shall develop policies and procedures to comply with 42 CFR §455.23.
- (B) The Contractor shall contact MFCU prior to suspending payments.

6.1.6 Service Verification

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

- (1) annually, the Contractor shall randomly select a minimum of 50 individual Enrollees who received a Covered Service during the state fiscal year (SFY) 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:

- (1) the names and ID numbers of all Enrollees contacted for service verification;
- (2) whether the Enrollees were contacted via telephone, email, or other method;
- (3) whether the Enrollee responded to the service verification; and

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

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

6.1.7 Subrogation of Claims Arising from Fraud

The Contractor agrees to be subrogated to the State for any claims the Contractor has or may have against pharmaceutical companies, retailers, Providers, or other Subcontractors, medical device manufacturers, laboratories or durable medical equipment manufacturers in the marketing and pricing and quality of their products. The Contractor shall not be entitled to any portion of the recovery obtained by MFCU.

6.2 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 that comply with the Act.

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

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

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

6.2.2 Information Required in False Claims Act Policies

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

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

6.2.3 Dissemination of False Claims Act Policies and Procedures

- (A) The Contractor shall have written procedures for disseminating False Claims Act Policies to its employees, contractors and agents.
- (B) The Contractor shall require that its Network Providers to comply with the Contractor's False Claims Act policies and procedures.
- (C) The Contractor shall use all reasonable efforts, including provider attestations, to ensure that its Network Providers are either disseminating the Contractor's or equivalent False Claims Act policies and procedures to the Network Providers' employees and agents.

6.2.4 Employee Handbook

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

6.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies

6.3.1 General Requirements

- (A) In accordance with Section 1932(d) of the Social Security Act:
 - (1) The Contractor shall not knowingly have a director, officer, partner, a Subcontractor as governed by 42 CFR 438.230, a Network Provider, or a 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 at 48 CFR 2.101, 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 disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

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

6.3.2 Screening for Prohibited Affiliations

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

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

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

(2) 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 obligations under this Contract with the Department.

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

- (1) Conduct searches of the 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), and (3) are debarred, Suspended, or otherwise Excluded; and
- (2) The Contractor shall maintain documentation showing that such searches were conducted.

(D) If the individuals listed in Article 6.3.2(B)(1), (2),(3),(4), and (5) are not found in the database searches, the Contractor is required to determine if the individual is an Affiliate 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. Affiliate is defined in Article 6.3.1(A)(2)(ii) of this Contract.

- (1) The Contractor may provide the Department's Prohibited Affiliation Attestation Form to the individuals listed in Article 6.3.2(B)(1), (2) and (3). If the Contractor chooses to use the Department's Prohibited Affiliation Form, the Contractor shall keep the original version of this form and shall provide the Department with an electronic copy of the form.
- (2) The Department's Prohibited Affiliation Attestation form includes a statement that if the individual completing the form subsequently becomes an affiliate of a person who is disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the individual must notify the Contractor within 30 days of the discovery and complete a new attestation form.

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

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

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

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

6.3.3 Subcontracted Administrative Functions

(A) In the event that the Contractor has entered into a Subcontract with an entity that will be performing administrative functions that are significant and material to the Contractor's obligations under this Contract, the Contractor shall ensure that Subcontractor does not have a prohibited affiliation of the type described in Section 6.3.1(A)(1), (2), and (3).

(B) The Contractor shall conduct the database searches and shall obtain attestations for individuals performing administrative functions locally to determine if any of the individuals are disbarred, Suspended, or otherwise Excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

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

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

(E) The Department will exclude from participation any managed care organization who has prohibited relationships as defined in 42 CFR 1002.203.

6.3.4 Reporting Prohibited Affiliations

(A) In the event that the Contractor determines that it is not in compliance and has entered into a prohibited affiliation of the type described in Article 6.3.1(A)(1), (2), or (3) of this Contract, the Contractor shall immediately, and no later than 30 days, notify the Department. Notification to the Department shall be by email and shall include the name, Social Security Number, and type of relationship the person has with the Contractor.

(B) If the Contractor obtains an Attestation from an individual stating that the individual has an affiliate who has been 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) The Department, after having been notified of the Contractor's noncompliance shall:

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

6.4 Excluded Providers

6.4.1 Definition of Excluded Providers

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

6.4.2 Screening for Excluded Providers

(A) The Contractor shall maintain written policies and procedures for conducting routine searches of the LEIE and EPLS databases and any other database required by the Department to 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 or CHIP 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 restricted Providers and maintain documentation showing that such searches were conducted.

(E) Once the Contractor has credentialed the potential Provider and enters into a Provider agreement, and the Provider is not Medicare-certified or is not a Medicaid Provider, the Contractor may delegate any of the following monthly searches:

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

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

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

(G) If the Contractor delegates the Exclusion searches to a Participating Provider, the Contractor shall include this requirement in its written Provider agreement. The Contractor shall require the Provider to have 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 monitoring policies and procedures to ensure its Providers are conducting the Exclusion searches in accordance with the delegation agreement.

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

6.4.3 Excluded Provider Payment Prohibition

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

6.5 Disclosure of Ownership and Control Information

6.5.1 Disclosure Information

(A) Using the Department-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 at the following times:

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

(2) Within 90 days of the Contractor executing the Contract with the Department.

(3) Within 90 days of renewal or extension of the Contract.

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

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

6.5.3 Consequences for Failure to Provide Disclosures

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

6.6 Disclosure of Provider Incentive Plans

6.6.1 Generally

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

6.6.2 Prohibition

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

6.6.3 Reporting Requirements

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

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

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

6.6.4 Substantial Financial Risk

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

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

6.6.5 Information to Enrollees

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

6.7 Cost Avoidance

The Contractor shall not avoid costs for services covered under this contract by referring Enrollees to publicly supported health care resources.

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 a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

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

(E) The Contractor shall 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 services to any Enrollee.

(F) The Contractor Service Authorization request comply with the requirements for parity in Mental Health and Substance Use Disorder in 42 CFR 457.496(d)(4)(i)

(G) The Contractor shall provide notice as expeditiously as the Enrollee's condition requires and within state-established timeframes that may not exceed 14 calendar days after receipt of request for service, with a possible extension of 14 days if the enrollee or provider requests and extension or the Contractor justifies the need for additional information and how the extension is in the enrollee's interest.

(H) The Contractor requires that when a Network Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health condition requires and no later than 72 hours after receipt of the request for service.

7.1.2 Time Frames and Procedures for Standard Service Authorizations

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

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

(i) the Enrollee or the Provider requests an extension; or

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

(2) If the Contractor extends the time frame for making standard Service Authorization decisions the Contractor shall:

(i) give the Enrollee written notice of the reason for the decision to extend the time frame;

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

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

7.1.3 Time Frames and Procedures for Denying All or Part of a Service Authorization

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

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

- (i) the Enrollee or the Provider requests an extension; or
 - (ii) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's best interest.
- (2) If the Contractor extends the time frame for making standard Service Authorization decisions the Contractor shall:
- (i) give the Enrollee written notice of the reason for the decision to extend the time frame;
 - (ii) inform the Enrollee of their right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and
 - (iii) issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

7.1.4 Time Frames and Procedures for Expedited Service Authorization Decisions

(A) For cases in which a Provider indicates, or the Contractor determines (on request from an Enrollee) that following the standard time frame could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall:

- (1) Make an expedited Service Authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after the receipt of the request for Service Authorization Request;
 - (i) The Contractor may extend the 72 hour time period by up to 14 calendar days if:
 - (a) the Enrollee requests the extension; or
 - (b) the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Enrollee's interest.

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

7.1.5 Service Authorization Decisions Not Reached Within Required Time Frames

In the event that the Contractor fails to make a Service Authorization decision within the proscribed time frames, such failure shall constitute a denial of services and shall be considered an Adverse Benefit Determination. The Contractor is required to send out a Notice of Adverse Benefit Determination to the Enrollee on the day that the time frame expires.

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

(A) If the Contractor terminates, suspends or reduces previously authorized Covered Services this constitutes an Adverse Benefit Determination. 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 time frames:

- (1) At least 10 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 he or she understands that this shall be the result of supplying that information;
- (4) The Enrollee has been admitted to an institution where he is ineligible for further services;
- (5) The Enrollee's whereabouts are unknown and the post office returns mail directed to him indicating no forwarding address. In this case any discontinued services shall be reinstated if his whereabouts become known during the time he is eligible for services;
- (6) The Enrollee has been accepted for CHIP services by another local jurisdiction; or
- (7) The Enrollee's physician prescribes the change in the level of medical care.

7.2 Other Actions Requiring Notice of Adverse Benefit Determination

7.2.1 Adverse Benefit Determination to Deny Payment in Whole or Part 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 Adverse Benefit Determination at the time of the Adverse Benefit Determination affecting a Claim if the denial reason is that:

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

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

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

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

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

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

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

The 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 Network provider informs the Contractor that the Network 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 time frame for resolving the Appeal or Grievance will not be met.

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

(C) When issuing a Notice of Adverse Benefit Determination due to failure to resolve an Appeal within the required timeframe, the Contractor shall include in the Notice of Adverse Benefit Determination information regarding the procedures and timeframes for filing a request for a

State Fair Hearing rather than information on filing an Appeal request. The Contractor shall also attach to the Notice of Adverse Benefit Determination, a copy of the request form for a State Fair Hearing that the Aggrieved Person can submit to request a State Fair Hearing.

7.3 Required Content of Notice of Adverse Benefit Determination

7.3.1 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 the following:

- (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 and 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 resolution of the Appeal;
- (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 service;
- (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)(7), and 431.230(b); and
- (10) The following timeframe for requesting 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 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 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 Enrollees may use as the written Appeal request for standard Appeals. The form may also be used for expedited Appeal requests if the Enrollee chooses to submit a written request for an expedited Appeals resolution, even though an oral request is all that is required. The form shall:

(1) include a mechanism for Aggrieved Persons to request an expedited Appeal (If they choose to submit a written expedited Appeal request);

(2) include a mechanism for the Enrollee, the Enrollee's legal guardian or other authorized representative to request continuation of services if the Adverse Benefit Determination is to reduce, suspend, or terminate previously authorized services; and include statements that:

(i) continuation of services must be requested within the later of the following: within 10 calendar days of the Contractor mailing the Notice of Adverse Benefit Determination, or by the intended effective date of the Contractor's proposed Adverse Benefit Determination, and if using this form to request an Appeal and continuation of services, that the form must be submitted within these timeframes; and

(ii) If continuation of services is requested and the Appeal decision is adverse to the Enrollee, that the Enrollee may be required to pay for the

continued services, to the extent that they were furnished solely because of the request for continuation of the services;

(3) Summarize the assistance available to the Enrollee may request 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 Enrollees or Providers of their State Fair Hearing rights, the Contractor shall not attach its own Appeal Request form but shall, instead, attach the State's request form for a Medicaid/CHIP State fair hearing.

Article 8: Grievance and Appeals Systems

8.1 Overall System

8.1.1 General Requirements

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

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

(2) an Appeals 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 Appeals requirements found in this Contract into its policies and procedures for Grievances and Appeals.

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

8.2 Appeal Requirements

8.2.1 Special Requirements for Appeals

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

(1) Provide that oral inquiries seeking to appeal an Adverse Benefit Determination be treated as an Appeal request; and

(2) Include as parties to the Appeal:

- (i) the Enrollee and their representative, or
- (ii) the legal representative of a deceased Enrollee's Estate.

8.3 Standard Appeals Process

8.3.1 Authority to File

- (A) An 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 or taking other procedural steps. 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 request either orally or in writing and explain to the Enrollee the process that must be followed to complete the Appeal.
- (D) The Contractor shall provide the Aggrieved Person reasonable opportunity to present evidence, testimony and allegations of facts or law, in person as well as in writing. 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 appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records, and any new or additional evidence, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal. considered during the appeals process. 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 not involved in any previous level of review or decision-making; nor 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) an Appeal of a denial that is based on lack of Medical Necessity; or

(ii) an Appeal that involves clinical issues and;

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

8.3.4 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. The written Notice of Appeal Resolution shall include the following:

(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;
- (3) how to request continuation of disputed services;
- (4) a statement that the Enrollee may be liable for the cost of disputed services provided if the State fair hearing decision upholds the Contractor's Adverse Benefit Determination;
- (5) the time frame for requesting a State Fair Hearing when continuation of disputed services is not requested and when continuation of disputed services is requested; and
- (6) a copy of the State Fair Hearing request form.

8.3.6 Continuation of Disputed Services During the Appeals Process

(A) The Contractor shall continue the Enrollee's disputed services during the 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 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 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 Contractor shall continue the disputed services until one of the following occurs:

- (1) the Aggrieved Person withdraws the Appeal or State Fair Hearing request;
- (2) 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;
- (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 service 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 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 was pending, the Contractor shall pay for those services in accordance with State policy and regulations.

8.4 Process for Expedited Resolution of Appeals

8.4.1 General Requirements

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

8.4.2 Authority to File

The Aggrieved 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 Aggrieved Person to present evidence and allegations of fact or law in person and in writing.

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

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

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

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

- (1) were not involved in any previous level of review or decision-making; and
- (2) if deciding any of the following, are health care professionals who have appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:
 - (i) an Appeal of a denial that is based on lack of Medical Necessity; or
 - (ii) an Appeal that involved clinical issues.
- (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 time frame of no longer than 30 calendar days from the day the Contractor receives the Appeal, with a possible 14 calendar day extension for resolving the Appeal and Providing Notice of Appeal resolution to affected parties;
- (2) Make reasonable effort to give the Aggrieved Person prompt oral notice of the denial; and
- (3) Mail written notice within two calendar days explaining the denial, specifying the standard time frame that must be followed, and informing the affected parties that the Aggrieved Person may file a Grievance regarding the denial of expedited resolution of an Appeal.

8.4.6 Time Frame for Expedited Appeal Resolution and Notification

(A) The Contractor shall complete each expedited Appeal and provide notice to affected parties as expeditiously as the Enrollee's health condition requires, but no later than three working days after the Contractor receives the expedited Appeal request.

(B) The Contractor may extend the time frame for 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 Aggrieved Person'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 to the affected parties with the format and language requirements found in that meets the same format and content requirements found in Article 3.6 of this Contract. 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 of the Enrollee, the Enrollee's legal guardian or other authorized representative to request continuation of services if the Appeal decision is to uphold the Adverse Benefit Determination to reduce, suspend or terminate services;
- (3) how to request on the State Fair Hearing request form continuation of these services during the State Fair Hearing; and
- (4) a statement that if the State Fair Hearing decision is adverse to the Enrollee, that the Enrollee may be required to pay for the continued services to the extent they were furnished solely because of the request for continuation of the services;
- (5) the timeframe for requesting a State Fair Hearing when continuation of services is not requested, and when continuation of services is requested; and
- (6) a copy of the Medicaid/CHIP State Fair Hearing request form

8.4.8 Continuation of Disputed Services During the Expedited Appeals Process

(A) The Contractor shall continue the Aggrieved Person 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 period covered by the original authorization has not expired;
- (4) the Aggrieved Person files a request for continuation of disputed services, and files 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

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 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;
- (3) a State fair hearing officer issues a hearing decision adverse to the Aggrieved Person;
or
- (4) the time period of service limits of a previously authorized service has been met.

(B) If the final resolution of the Appeal or State fair hearing is adverse to the Aggrieved Person, 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 they were furnished solely because they were furnished according to the requirements found in Article 8.4.8 of this Contract and in accordance with 42 CFR 431.230(b).

8.4.10 Reversed Appeal Decisions

(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 Aggrieved Person'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 party or parties who initiated the Appeal of the outcome and explain in clear terms a detailed reason for the denial.

(B) The Contractor shall provide notification to the Aggrieved 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. The Contractor shall inform the Enrollee and Provider the time frame 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 Aggrieved Person 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 Aggrieved Person who may include legal counsel, a relative, a friend or other spokesman, or the representatives of a deceased Aggrieved Person'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 Aggrieved Person'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 Aggrieved Person filed an appeal with the Contractor, not including the number of days the Enrollee took to subsequently file for a State fair hearing; or
 - (ii) where permitted, the date the Aggrieved Person filed for direct access to a State Fair Hearing;
- (2) The State Fair Hearing shall take final administrative action as expeditiously as the Aggrieved Person'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 Aggrieved Person.

8.6 Grievances

8.6.1 Authority to File a Grievance

An Aggrieved Person as defined in Article 2.1 may file a Grievance with the Contractor.

8.6.2 Procedures

- (A) The Aggrieved Person may file a Grievance orally or in writing.
- (B) The Contractor shall give the Aggrieved Person 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; and
 - (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the Department, in treating the Aggrieved Person'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.
 - (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 Aggrieved Person'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 Aggrieved Person files a Grievance with the Department, the Department shall apprise the Enrollee or the Provider, of their right to file the Grievance with the Contractor and how to do so.
 - (1) If the Individual prefers, the Department shall promptly notify the Contractor of the Aggrieved Person's Grievance.

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

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

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

(1) the Aggrieved Person requests the extension; or

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

(E) If the Contractor extends the time frame, and the extension was not requested by the Aggrieved Person, the Contractor shall:

(1) make reasonable efforts to give the Aggrieved Person prompt oral notice of the delay; and

(2) give the Aggrieved Person written notice, within two calendar days, of the decision to extend the timeframe and inform the Aggrieved Person of the right to file a State Fair Hearing 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 time frame 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) copies of written Notice of Appeal Resolution; and
- (12) 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 Aggrieved Person 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 Aggrieved Person was notified of the resolution and how the Aggrieved Person was notified (either orally or in writing). If the Aggrieved Person was notified of the disposition in writing, the Contractor shall maintain a copy of the written notification.

(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 are 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 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 their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3 Objection to Services on Moral or Religious Grounds

9.3.1 Generally

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

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

and

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

(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 (sex and religion) as other Federal laws and regulations protect against these forms of discrimination.

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

religion, disability, or age.

10.1.2 General Standards

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

- (1) Executive management with clear oversight authority for all other functions;
- (2) Medical Director's Office;
- (3) Accounting and Budgeting function
- (4) Member Services Function
- (5) Provider Services Function
- (6) Medical Management function, including quality assurance and utilization review;
- (7) Enrollee and Provider complaint and Grievance resolution function;
- (8) Management of Contractor's information system.

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

10.1.3 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 Contractor's Health Plan and its CHIP managed care policies and provide training, as needed

10.1.4 Provider Services Function

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

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

- (1) training, including ongoing training, of the Contractor's Providers on CHIP rules and regulations that shall enable Providers to appropriately render services to Enrollees;
- (2) assisting Providers to verify whether an individual is enrolled with the Contractor's Health Plan;
- (3) assisting Providers with prior authorizations and referral protocols;
- (4) assisting Providers with claims payment procedures, 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.

10.1.5 Contractor Licensure

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

10.1.6 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 frequent than:

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

(2) on an annual basis; and

(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 Contractor's Health Plan.

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

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

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

(C) The Contractor shall guarantee equal access to services and benefits for all Enrollees by making available interpreters, telecommunication devices for the Deaf (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 telephonic communications to ensure that Enrollees are able to communicate with the Contractor and the Contractor's Network Providers and receive Covered Services.

(B) Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. A family member or friend may be used as an interpreter if this method is requested by the Enrollee, and the use of such a person would not compromise the effectiveness of services or violate the Enrollee's confidentiality, and the Enrollee is advised that a free interpreter is available. (C) The Contractor shall ensure interpretive services are provided in compliance with 45 CFR 92.201.

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

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

10.2.4 Cultural Competence Requirements

(A) The Contractor shall ensure the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

(B) The Contractor shall incorporate in its policies, administration, and delivery of services the values of honoring Enrollee's beliefs; being sensitive to cultural diversity; and promoting attitudes and interpersonal communication styles with staff and 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 Participating Provider who can communicate with the Enrollee and provide care with sensitivity, understanding, and respect for the Enrollee's culture, background, and beliefs.

(D) The Contractor shall strive to ensure its 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 their health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

10.2.6 Waiting Time Benchmarks

(A) The Contractor shall adopt benchmarks for waiting times for physician appointments as follows:

(1) Benchmarks for Waiting Times for Appointments with a Primary Care Provider:

- (i) within 30 days for a routine, non-urgent appointments
- (ii) within 30 days for school physicals
- (iii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

(2) Benchmarks for Waiting Times for Appointments with a Specialist:

- (i) within 30 days for non-urgent care
- (ii) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a provider'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 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 their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity;

(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 received through FFS Medicaid or any other MCO, PIHP, or PAHP; 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 the dental 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.

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 their 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 their 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 Special Rules for Enrollees with Special Health Care Needs

(A) The Department shall identify Enrollees with Special Health Care Needs. The Contractor shall have a mechanism in place to allow Enrollees with Special Health Care Needs to directly access to a specialist.

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

treatment or regular care monitoring.

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 Participating Provider as an Enrollee for any Covered Service.

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

10.4.2 Circumstances in Which an Enrollee May Be Billed

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

(B) A non-Covered Service is a service that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee (e.g., more expensive eyeglass frames, hearing aids, custom wheelchairs, etc.) but does not meet the Medical Necessity criteria for amount, duration, and scope as set forth in the State Plan or is not authorized by the Contractor.

(C) The Department shall specify to the Contractor the extent of Covered Service and items under the Contract.

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

- (1) the Provider has an established policy for billing all patients for services not covered by a third party (i.e., the charge cannot be billed only to Enrollees);
- (2) the Provider has informed the Enrollee of its policy for billing patients for non-covered services;
- (3) the Provider has advised the Enrollee prior to rendering the non-covered service that the Enrollee shall be responsible for making payment; and
- (4) an agreement, in writing, is made between the Provider and the Enrollee that details the service and the amount to be paid by the Enrollee.

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

10.4.3 Prohibition on Holding Enrollee’s CHIP Card

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

10.4.4 Criminal Penalties

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

10.5 Survey Required

10.5.1 General Requirements

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

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

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

Article 11: Network Provider Practice Guidelines

11.1 Network Provider Practice Guidelines, Generally

(A) The Contractor and its Network Providers shall develop or adopt practice guidelines consistent with current standards of care as recommended by professional groups such as the American Academy of Pediatrics and the U.S. Preventative Services Task Force. The practice guidelines shall meet the following requirements:

- (1) guidelines shall be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- (2) guidelines shall consider the needs of the Contractor’s Health Plan Enrollees;
- (3) guidelines shall be adopted in consultation with contracting health care professionals; and
- (4) guidelines shall be reviewed and updated periodically as appropriate.

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

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

Article 12: Payments

12.1 General Payment Provisions

12.1.1 Comprehensive Risk Contract

This Contract is a Comprehensive Risk Contract.

12.1.2 Payment Methodology

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

12.1.3 Contract Maximum

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

12.1.4 Payment Recoupment

(A) The Department shall recoup any payment paid to the Contractor that 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 Enrollee eligibility for CHIP, 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.

12.1.5 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 Capitation Payments or other payments in excess of amounts specified in the Contract;
- (2) the retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse;

(3) the process, timeframes, and documentation required for reporting 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 Network Providers 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 the 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.

12.1.6 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 12.1.6.1 and 12.1.6.2 of this Article apply.

12.17 Collection and Retention of Overpayments Related to Fraud, Waste, or Abuse

The Contractor may collect and retain Overpayments it recovers during the Recovery Period.

12.1.8 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 13.4.1

12.1.9 Prohibition on Balance Billing

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

12.1.10 Department Retraction of Capitation Payments

(A) The Department may retract a Capitation Payment from the Contractor in the event that:

- (1) the Enrollee changes Health Plans;
- (2) the Enrollee becomes eligible for Medicaid; or
- (3) an error made by the Department has resulted in an inappropriate Capitation Payment being paid to the Contractor.

12.2 Third Party Liability and Coordination of Benefits

12.2.1 Recovery of Third Party Liability, Generally

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

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

12.2.2 Notification to Department

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

12.3 Contractor's Payment Responsibilities

12.3.1 Covered Services Delivered by Non-Network Providers but Paid by the Contractor

(A) The Contractor shall not be required to pay for Covered Services when the Enrollee receives

the services from Non-Network Providers, not arranged for and not authorized by the Contractor except as follows:

- (1) Emergency Services;
- (2) court ordered services that are Covered Services defined in Attachment C;
- (3) cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the Contractor's Network Providers; and
- (4) covered Services received between the Enrollee's effective dates of eligibility but before the Enrollee reasonably could have known which Providers were Network Providers.

(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.

12.3.2 Payment to Non-Network Providers

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

- (1) The usual charges made to the general public by the Provider; or
- (2) the rate agreed to by the Contractor and the Provider.

12.3.3 Covered Services which are Not the Contractor's Responsibility

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

12.3.4 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 shall reimburse DFHP at the standard CHIP rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee becomes a CHIP Eligible Individual and selects the Contractor as its Health Plan.

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

(2) the services provided in the outpatient team evaluation and follow-up visit for which the Contractor shall reimburse DFHP are limited to the services that the Contractor is otherwise obligated to provide under this Contract.

(B) If the Contractor desires a more detailed agreement for additional services to be provided by or through DFHP for Children with Special Health Care Needs, the Contractor may subcontract with DFHP. The Contractor agrees that the subcontract with DFHP shall acknowledge and address the specific needs of DFHP as a government provider.

12.3.5 Payments for Vaccines for Children

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

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

12.4 Enrollee Transition Between the CHIP Health Plan, Medicaid MCO and Medicaid Fee-for-Service (FFS)

12.4.1 Transition of Care Policy

The Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets the state defined transition of care policy outlined in 12.2.2 through 12.4.9 of this Contract.

12.4.2 Enrollee Transition, Inpatient Hospital Stays

(A) When an Enrollee is in an inpatient hospital setting and transitions to a another CHIP Health Plan, or becomes eligible for Medicaid any time prior to discharge from the hospital, the Contractor is financially responsible for the entire hospital stay including all Covered Services related to the hospital stay until discharged.

(B) If a CHIP Eligible Individual was Medicaid Fee-for-Service or enrolled in a Medicaid MCO when admitted to the hospital and becomes enrolled in the Contractor's Health Plan at any time prior to discharge from the hospital, the Department or the Medicaid MCO is financially responsible for the entire hospital stay including all Covered Services related to the Hospital stay until discharged.

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

(D) When an Enrollee is in an inpatient hospital setting and becomes ineligible for CHIP any time prior to discharge from the hospital, the Contractor is financially responsible for the inpatient hospital only for the period of eligibility.

(E) When an Enrollee in an inpatient hospital setting, loses eligibility and then later becomes

eligible retroactively for CHIP, without a break in CHIP coverage , then the Contractor is financially responsible for the inpatient hospital stay described in 12.4.2(A).

12.4.3 Enrollee Transition, Home Health Services

(A) Enrollees who are enrolled in a CHIP Health Plan other than the Contractor’s Health Plan and are receiving home health services from an agency not contracting with the Contractor, but who will transition to the Contractor’s Health Plan, shall be transitioned to the Contractor’s home health agency.

(B) The Contractor shall pay the In-Network rate for services provided by an Non-Network Home Health Agency for an Enrollee until the Home Health Agency enrolls as a Network Provider with the Contractor, or the Contractor provides an assessment for the Enrollee and transitions an Enrollee to an In-Network Home Health Agency.

(C) The Contractor shall include the Enrollee in developing the plan of care to be provided by the Contractor’s In-Network Home Health Agency before the transition is complete. The Contractor shall make reasonable efforts to address the Enrollee’s concerns regarding Covered Services provided by the Contractor’s In-Network Home Health Agency before the new plan of care is implemented.

12.4.4 Enrollee Transition, Medical Equipment

(A) When medical equipment is ordered for an Enrollee by the Contractor and the Enrollee enrolls in a different Health Plan or becomes Medicaid Fee-for-Service before receiving the equipment, the Contractor is responsible for the payment of such equipment.

(B) When medical equipment is ordered for a CHIP Eligible Individual by the Department and the CHIP Eligible Individual selects a Health Plan, the Department is responsible for payment of such equipment.

(C) Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual client. Any attachments to the equipment, replacements, or new equipment are the responsibility of:

- (1) The Contractor if the Enrollee is enrolled with the Contractor at the time the equipment is ordered or;
- (2) the Department if the Enrollee is Medicaid Fee-for-Service at the time the equipment is ordered or;
- (3) the MCO if the Enrollee is enrolled with and MCO at the time the equipment is ordered

12.4.5 Department Acceptance of Contractor’s Service Authorization

When the Contractor has given a Service Authorization for a Covered Service other than inpatient, medical equipment, or organ transplantations, and an Enrollee transitions to Medicaid

Fee-for-Service prior to the delivery of such Covered Service, the Department shall be bound the Contractor's Service Authorization until the Department has evaluated the Medical Necessity of the service and agrees with the Contractor's Service Authorization or has made a different determination.

12.4.6 Pharmacy Service Authorizations

The Contractor agrees that during the first 90 days of an enrollment in CHIP that the Medicaid Fee-For-Service Service Authorization for pharmacy services or a Service Authorization which has been issued by another Health Plan to an Enrollee in the Contractor's Health Plan for pharmacy services will be honored for at least one temporary 30 day fill unless the prescription is written for less than 30 days by the prescriber.

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

When CHIP Eligible Individuals are transitioned from the Contractor's Health Plan to Medicaid Fee-for-Service or from Medicaid Fee-for-Service to the Contractor's Health Plan, the Contractor and the Department, as applicable, shall submit upon request any critical medical information about the transitioning CHIP Eligible Individual prior to the transition, including, but not limited to, whether the member is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, names of the treating physicians, types of equipment ordered and dates, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis or is chronically ill. Chronic illness includes, but is not limited to, diabetes, hemophilia, or HIV.

12.4.8 Acceptance of Pre-Enrollment Service Authorization

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

12.4.9 Enrollee Transition, Organ Transplantations

The Contractor shall honor prior authorizations for organ transplantations initiated by the Department while the Enrollee was covered under Medicaid Fee-for-Service until the Enrollee is evaluated by the Contractor and a new plan of care is established.

Article 13: Additional Recordkeeping and Reporting Requirements

13.1 Recordkeeping Requirements

13.1.1 Health Information Systems, General Requirements

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

Medicaid eligibility.

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

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

13.1.2 Accuracy of Data

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

(1) Verifying the accuracy of the reported data, 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.

13.1.3 Medical Records

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

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

13.1.4 Document Retention Requirements for Awards

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

(1) if any litigation, Claim, financial management review or audit is started before the expiration of the 3 year period, the records shall be retained until all litigation, Claims, or

audit findings involving the records have been resolved and final action apply;

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

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

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

13.1.5 Record Retention Requirements, Generally

(A) Unless otherwise specified by this Contract or by state or federal law, the Contractor shall keep all documents and reports required by this Contract for a period of 6 years. Such documents include, but are not limited to, the attestation forms required by Article 6.3.2, Contractor's policies and procedures, Contractor's Enrollee handbooks, and copies of reports required by the Department.

(B) The Contractor shall retain, and shall require its Subcontractors to retain Grievance and Appeal records, 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.

13.2 Additional Reporting Requirements

13.2.1 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.

13.2.2 Enrollment, Cost and Utilization Reports

(A) The Contractor shall submit an enrollment, cost and utilization report in a 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); and

(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.

13.2.3 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) A report of the number of organ transplants by type of transplant;
- (2) the Grievance and Appeals reports required by Article 8.7.1 of this Contract;
- (3) the state requires the Managed Care Plans to submit semi-annual reports summarizing information on corrective actions taken on physicians who have been identified by the Managed Care Plans as exhibiting aberrant physician behavior; and
- (4) the Contractor shall submit a report describing the number of claims processed. The report will include the number of claims submitted, the number of clean claims submitted, the number of clean claims paid within 30 days, and the number of clean claims paid within 90 days. The report will also provide the percentage of clean claims paid within 30 days and the percentage of clean claims paid within 90 days.

13.2.4 Provider Network Reports

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

13.2.5 Case Management Reports

The Contractor shall submit annual case management reports no later than November 1 of each year for the preceding fiscal year. The report shall be in a format designated by the Department.

13.2.6 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 calendar days of the request.

13.2.7 Additional Reporting Requirements

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

- (1) The Contractor shall submit formally collected and audited HEDIS data to the Department. Audited HEDIS performance measures will cover services rendered during

each calendar year and will be reported as set forth in state rule by the Office of Health Care Statistics or HEDIS measures will be calculated based on submitted encounter data by the Department;

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

(3) on a monthly basis, the Contractor shall submit to the Department a report describing the time it takes for Enrollees to be sent their ID cards. Reporting will occur in the second month after the Contractor receives the enrollment information. For example, the report for enrollees whose enrollment information was received by the Contractor in January would be reported in March to the Department. The due date for this report is the last day of the month. The report will detail:

(i) The number of ID cards sent within the following time periods calculated in calendar days: 0-21 days; over 21 days; and not yet sent and;

(ii) the overall average number of days. The number of days will be calculated starting the day the Contractor receives enrollment information from the Department and ending the day the Contractor sends the ID card.

(4) upon request, the Contractor shall provide the Department its list of CHIP covered codes within two weeks of the request;

(5) the Contractor shall report quality measures as required by CMS and those measures designated by the Quality Improvement Council; and

(6) annually, on November 1, the Contractor shall submit a report showing when the appointment and waiting time benchmarks were not met for the year ended June 30. The report shall be in a format specified by the Department.

13.2.8 Development of New Reports

The Department may request other reports deemed necessary to the Department to assess areas including, but not limited to, access and timeliness or quality of care. The Contractor agrees to submit any report requested by the Department within the time frames specified by the Department.

13.2.9 Data Collection

(A) By July 1st of each year, the Contractor shall provide the following information to the Department:

(1) the results of any Enrollee or Provider satisfaction survey conducted by the Contractor and;

- (2) Utilization Review Committee reports and minutes and;
- (3) customer services performance data.

13.2.10 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.

13.3 Encounter Data

13.3.1 Encounter Data, General Requirements

(A) In accordance with Section 1903(m)(2)(A)(xi) of the Social Security Act, the Contractor agrees to maintain sufficient patient Encounter Data to identify the physician who delivers Covered Services to Enrollees.

(B) The Contractor shall transmit 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 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 date at least 95 percent of its Encounter Data within the timely submission standard in 13.3.1(D), the Department may require corrective action.

(F) The Contractor shall submit Encounter Data for all services rendered to Medicaid Enrollees under this Contract, including:

- (1) services that the Contractor has determined no liability exists;
- (2) services that the Contractor did not pay a Claim;
- (3) services provided under a special arrangement with another facility or program and;
- (4) services provided to Medicaid 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 the 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 instruction. 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.

13.3.2 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.

13.3.3 Encounter Data for Rate Setting

The Department will use for rate setting only the Encounter Data received by the Department's deadline.

13.3.4 Non-Encounter Data

(A) The Contractor shall submit to the Department, no later than 60 calendar days after the end of each quarter a “Non-Encounter” data report. The report shall be in a Department-specified format. The Contractor shall follow the Department’s instructions in filling out the report and shall not change the format of the report.

(B) The submission of all other Non-Encounter data is voluntary and it is the Contractor’s responsibility to provide whatever data the Contractor deems relevant.

13.4 Disallowance of Claims

13.4.1 Procedures for Incorrectly Paid Claims

(A) The Contractor shall take reasonable action to collect any incorrectly paid Claim from the Provider within 12 months of the date of discovery of the incorrectly paid Claim. Incorrectly paid Claims include but are not limited to claims which were duplicative, overpaid, or disallowed.

(B) The Contractor shall reverse the Encounter Data for the incorrectly paid Claims within 60 calendar days of the earlier of the date of discovery of an incorrectly paid Claim or the date of the notice of 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 15.

(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.

13.5 Medical Loss Ratio

13.5.1 Medical Loss Ratio, Generally

- (A) The Contractor shall calculate and report to the Department an MLR consistent with the MLR standards described in Article 13.5
- (B) The Contractor shall create MLR data reports for all CHIP eligibility groups covered under the Contract unless the Department requires separate reporting and a separate MLR calculation for specific populations.

13.5.2 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.

13.5.3 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.

13.5.4 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 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.

13.6 Data Submission and Certification

13.6.1 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).

(8) corrected encounters for all Overpayment recoveries collected by the Contractor and the Utah OIG.

(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.

13.6.2 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 13.6.1 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 individual certifying the Encounter Data attests to the completeness and truthfulness of the data and documents based on the individual's knowledge, information and belief in accordance with 42 CFR 438.606.

Article 14: Compliance and Monitoring

14.1 Audits

14.1.1 Inspection and Audit of Financial Records

(A) The Department and the federal government may inspect and audit any books and/or records of the Contractor or its 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 Department of Health and Human Services awarding agency, the U.S. Comptroller General, or any of their duly authorized representatives, to access to any books, documents, papers, and records of the Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions.

14.1.2 Additional Inspections and Audits

(A) The Contractor shall place no restrictions on the right of the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law to conduct whatever inspections and audits that are necessary to assure contract compliance, quality, appropriateness, timeliness and accessibility of services and reasonableness of Contractor's costs.

(B) Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other client data, or review of written policies and procedures and other documents.

(C) The Department, CMS, the Utah OIG, the Comptroller General, and their designees may, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, inspect the premises, physical facilities, and equipment where CHIP-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.

14.1.3 Information to Determine Allowable Costs

(A) The Contractor shall make available to the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the CHIP program for “related party/home office” transactions, as defined by CMS Manual 15-1.

(B) The records described in Article 13.1.3(A) shall be made available in Salt Lake City, Utah or the Contractor shall pay the increased cost of auditing at an out-of-state location. The increased costs shall include round-trip travel and two days of lodging and per diem. Additional travel costs of the out-of-state audit shall be shared equally by the Contractor and the Department.

14.1.4 Management and Utilization Audits

(A) The Contractor shall allow the Department, the federal government, independent quality review examiners, and other Utah state agencies as allowed by law, to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, Fraud-related data, Abuse-related data, patient outcome data, and cost utilization data, which shall include patient profiles, exception reports, etc.

(B) The Contractor shall provide all data required by the Department, the federal government, independent quality review examiners, and other Utah state agencies allowed to conduct such audits.

14.2 Department and Contractor Quality Control

14.2.1 Quality Improvement Reports

(A) Annually, the Contractor shall submit to the Department the following signed 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.

(C) The reports listed in Article 14.2.1 shall be due on August 31 of each year.

14.3 Utah Office of the Inspector General

14.3.1 General Requirements

(A) The Contractor shall cooperate with the Utah Office of Inspector General for Medicaid and CHIP services (OIG) in any performance or financial audit of Medicaid and CHIP funds received by the Contractor as allowed by Utah Code Ann. §63A-13-202(2).

(1) Records requested by the Utah OIG must be provided within 30 calendar days in accordance with Utah Administrative Code R367-1-7.

(2) The Utah OIG shall determine 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 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 15: Corrective Action and Sanctions

15.1 Corrective Action Plans

15.1.1 Corrective Action Plans, Generally

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department may impose a corrective action plan to cure the Contractor's non-compliance.

(B) At the Department's discretion, the corrective action plan may be developed by the Department or the Contractor.

15.1.2 Department-Issued Corrective Action Plan

(A) The Department may develop a corrective action plan which the Department shall provide to the Contractor, in writing.

(B) The Contractor agrees to comply with the terms of a Department-issued corrective action plan and to complete all required actions within the required timeframes. The Department shall provide the Contractor with a reasonable amount of time to complete the corrective action plan. If the Contractor fails to satisfactorily complete the Department's corrective action plan, the Department may assess liquidated damages in accordance with Article 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.

15.1.3 Contractor Generated Corrective Action Plan

(A) The Department may require the Contractor to create its own corrective action plan. In such instances, the Department shall send a written notice to the Contractor detailing the Contractor's non-compliance. The notice shall require the Contractor to develop a corrective action plan.

(B) Unless otherwise specified in the notice from the Department, the Contractor shall have 20 calendar 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.

15.1.4 Notice of Non-Compliance

(A) In the event that the Contractor fails to comply with its obligations under this Contract, the Department shall provide to the Contractor written notice of the deficiency, request or impose a corrective action plan and/or explain the manner and time frame in which the Contractor's non-compliance must be cured. If the Department decides to explain the manner in which the Contractor's non-compliance must be cured and decides not to impose a corrective action plan, the Department shall provide the Contractor at least 30 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.

15.2 Capitation Payment Suspension

15.2.1 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;
- (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 10 days prior to 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.

15.2.2 Procedure for Capitation Payment Suspension

(A) The Department shall notify the Contractor, in writing, of any suspension of a Capitation Payment and the reason for that suspension. The Department shall inform the Contractor what action needs to be taken by the Contractor to receive payment and the timeframe in which the Contractor must take action in order to avoid suspension of the Capitation Payment. If the Contractor fails to cure the deficiency, the Department may continue the suspension of Capitation Payments until the Contractor comes into compliance. Once the Contractor comes into compliance, all suspended Capitation Payments will be paid to the Contractor within 14 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 State fair hearing officer to release the Capitation Payments.

15.3 Liquidated Damages

15.3.1 Liquidated Damages, Generally

(A) If the Contractor fails to perform or does not perform in a timely manner provisions under this Contract, damages to the Department may result. The Parties agree that the damages from breach of this Contract may be incapable or very difficult of accurate estimation.

(B) Should the Department choose to impose liquidated damages, the Parties agree that the following damages provisions represent a reasonable estimation of the damages that would be suffered by the Department due to the Contractor's failure to perform. Such damages to the Department would include additional costs of inspection and oversight incurred by the Department due to 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 \$500,000 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.

15.3.2 Liquidated Damages, Per Day Amounts

(A) The Department may assess the following damages against the Contractor for each date beyond the deadline that the Contractor was required to take the following actions:

- (1) \$300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;
- (2) \$400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;
- (3) \$1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 13.3) or the Post Adjudication Pharmacy file (as required by Article 4.14.8);
- (4) \$1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 13.3) or Post Adjudication History file (as required under Article 4.14.8);
- (5) \$2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the time frames established under Article 11.2.5.
- (6) \$500 per calendar day the Contractor fails to submit or comply with corrective action plan;
- (7) \$500 per calendar day that the Contractor fails to provide audit access as required by Article 14.1;
- (8) \$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.

15.3.3 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 Participating Provider as required by Article 5.3 of this Contract (including a failure to search the LEIE database, or has Provider agreements that do not meet the requirements of Article 5.3) and such failure to credential requires Department intervention or supervision.

(2) \$1,000 per each occurrence where the Contractor fails to provide an Enrollee access to Covered Services as required by this Contract and such failure requires Department intervention or supervision.

15.4 Sanctions Allowed by Federal Law

15.4.1 Reasons for Imposition of Intermediate Sanctions

(A) In accordance with 42 CFR 438.700, the Department may impose intermediate sanctions when the 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 CHIP program;

(3) acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a client, except as permitted under the CHIP program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future medical services;

(4) misrepresents or falsifies information that it furnishes to CMS or the Department;

(5) misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or health care provider;

(6) fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210;

(7) has distributed directly or indirectly through any agent or independent contractor marketing materials that have not been approved by the Department or that contains false or 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.

15.4.2 Types of Intermediate Sanctions

(A) The Department may impose any or all of the following intermediate sanctions:

(1) Civil monetary penalties in the amounts specified in 42 CFR 438.704.

(2) Appointment of temporary management of the Contractor as provided in 42 CFR 438.706 and this Contract.

(3) Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.

(4) Suspension of all new enrollment, including default enrollment, after the effective date of sanction.

(5) Suspension of payment for clients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

15.4.3 Notice of Sanction

(A) In accordance with 42 CFR 438.710, the Department shall provide the Contractor with timely written notice before imposing any of the intermediate sanctions specified in Article 15.4.2. The notice shall explain the basis and the nature of the sanction.

(B) The Contractor has 30 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 15.4.2, the Contractor may request a State fair hearing. The Department may continue to impose the sanction through the duration of the State fair hearing unless the hearing officer orders otherwise.

15.4.4 Discretionary Imposition of Temporary Management

(A) Pursuant to 42 CFR 438.706, the Department may impose temporary management of the administration of the Contractor's CHIP operations only if it finds (through onsite survey, Enrollee complaints, financial audits, or any other means) that:

- (1) there is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 CFR 438.700 or that is contrary to any requirements of Section 1903(m) and Section 1932 of the Social Security Act;
- (2) there is substantial risk to the Enrollee's health; or
- (3) the sanction is necessary to ensure the health of the Contractor's Enrollees while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the Contractor.

15.4.5 Required Imposition of Temporary Management

(A) In accordance with 42 CFR 438.706, the Department shall impose temporary management of the administration of the Contractor's CHIP operations (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act.

(B) The Department shall grant Enrollees the right to terminate enrollment without cause and shall notify Enrollees of their right to terminate Enrollment.

15.4.6 Hearing on Temporary Management

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

15.4.7 Duration of Temporary Management

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

15.4.8 Sanctions Imposed by CMS: Denial of Payment

The Department may recommend that CMS deny payments to new Enrollees in accordance with 42 CFR 438.730.

Article 16: Termination of the Contract

16.1 Termination of the Contract

16.1.1 Automatic Termination

This Contract shall automatically terminate on June 30, 2024

16.1.2 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.

16.1.3 Termination for Failure to Agree Upon Rates

At least 60 days prior the end of each state fiscal year, or as otherwise determined by the Department, the Parties shall meet and negotiate in good faith the rates (Attachment E) applicable to the upcoming year. If the Parties do not agree upon future rates by the end of the Contract year, either Party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 calendar days after receipt of the written notice of termination. A termination under this Section 15.1.3 shall not be considered a termination without cause.

16.1.4 Effect of Automatic Termination or Termination Without Cause

(A) The Contractor shall continue providing the Covered Services required by this Contract until midnight of the last calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the Contractor is responsible for the entire hospital stay (including physician and other ancillary charges) until discharge or 30 calendar days following termination, whichever occurs first.

(B) 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 Participating Provider, or the Subcontractor.

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

16.2 Termination of Contract With Cause

16.2.1 Termination of Contract With Cause, Generally

(A) In accordance with 42 CFR 438.708, the Department may terminate this Contract and enroll the Contractor's Enrollees in other MCOs or PCCMs or provide their CHIP benefits through other options included in the State Plan, if the Department determines that the Contractor has failed to:

- (1) carry out the substantive terms of this Contract; or
- (2) meet the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act.

16.2.2 Pre-Termination Hearing

(A) In accordance with 42 CFR 738.710, before terminating the Contract pursuant to Section 16.2.1 of this Contract, the Department shall provide the Contractor with a pre-termination hearing. The Department shall:

- (1) Give the Contractor written notice of its intent to terminate, the reason for the termination, and the time and place of the hearing;
- (2) After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of the termination; and
- (3) For an affirming decision, give Enrollees notice of termination and information consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of the termination.

(B) In accordance with 42 CFR 438.722, after the Department notifies the Contractor that it intends to terminate the Contract, the Department may give Enrollees written notice of the Department's intent to terminate the Contract and may allow Enrollees to disenroll immediately, without cause.

16.2.3 CMS Direction to Terminate

In the event that CMS directs the Department to terminate this Contract, the Department shall not be permitted to renew this Contract without CMS consent.

16.3 Close Out Provisions

16.3.1 Close Out Provisions 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 17: Miscellaneous Provisions

17.1 Additional Provisions

17.1.1 Integration

This Contract and all attachments hereto, contain the entire agreement between the Parties with respect to the subject matter of this Contract. There are no representations, warranties, understandings, or agreements other than those expressly set forth herein. Previous contracts between the Parties hereto and conduct between the Parties which precedes the implementation of this Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof. Notwithstanding Attachment A, General Provisions, Article III, item 27, if there is a conflict between this Attachment B, Special Provisions, and the Attachment A, General Provisions, then this Attachment B shall control.

17.1.2 Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees, no Enrollee is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to an Enrollee or Potential Enrollee.

17.1.3 Interpretation of Laws and Regulations

The Department shall be responsible for the interpretation of all federal and state laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Contractor shall submit a written request to the Department. The Department shall retain full authority and responsibility for the administration of the CHIP program in accordance with the requirements of Federal and State law.

17.1.4 Severability

If any provision of this Contract is found to be invalid, illegal, or otherwise unenforceable, the unenforceability of that provision will not affect the enforceability of any other provision contained in this Contract and the remaining portions of this Contract shall continue in full force and effect.

17.1.5 Assignment

Assignment of any or all rights or obligations under this Contract without the prior written consent of the Department is prohibited. Sale of all or part of the right or obligations under this Contract shall be deemed an assignment. Consent may be withheld in the Department's sole and absolute discretion.

17.1.6 Continuation of Services During Insolvency

If the Contractor becomes insolvent, the Contractor shall continue to provide all Covered Services to Enrollees for the duration of the period for which the Department has paid monthly

Capitation Payments to the Contractor.

17.1.7 Surveys

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

17.1.8 Policy, Rules, and Regulations

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

17.1.9 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 shall meet the solvency standards required by 42 CFR 438.116(b)(1).

17.1.10 Providers May Not Enforce Contract

Although this Contract relates to the provision of benefits by Providers, no Provider is entitled to enforce any provision of this Contract against the Contractor and nor shall any provision of this Contract constitute a promise by the Contractor to a Provider.

17.1.11 ACA Health Insurer Fee

(A) The Contractor is responsible for paying the annual Health Insurer Fee.

(B) The Department shall fund the Health Insurer Fee up to the amount appropriated by the Utah Legislature. The Department may request an appropriation from the Utah Legislature for additional funding in the event the Department determines that the amount appropriated by the Utah Legislature does not adequately cover the Health Insurer Fee.

(C) Absent a moratorium, by September 30 of each year, the Contractor shall provide to the Department the Contractor's Health Insurer Fee invoice relating to the Capitation Payments paid to the Contractor under this contract. The Contractor shall also provide any additional

supporting documentation relating to the Health Insurer Fee requested by the Department.

(D) Absent a moratorium, and with CMS approval, the Department shall pay the Contractor the amount of the Health Insurer Fee through a supplemental payment within 90 calendar days of receipt of the invoice per 17.1.11(C).

(E) The Contractor shall not pursue legal action whatsoever against the Department or its officers, employees, or agents with respect to the Health Insurer Fee.

17.1.12 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.

17.2 Access to the Controlled Substance Database

17.2.1 Application for Access

(A) In accordance with Utah Code Ann. § 58-37f-301(2)(e), the Contractor may make a written application to the Department for authorization for its employees to have access to the Controlled Substance Database.

(B) When designating an employee as needing access to the Controlled Substance Database the Contractor shall certify that the person is employed by the Contractor.

17.2.2 Criminal Background Report

(A) The Contractor shall conduct a criminal background report for each employee which the Contractor is applying for access to the Controlled Substance Database.

(B) The criminal background report shall be issued by the Utah Bureau of Criminal Identification and shall be provided to the Department as part of the Contractor's application for employee access to the Controlled Substance Database.

(C) The Department shall approve access to any employee whose criminal background report shows that the employee has not been arrested, charged, or convicted of any misdemeanor or felony within the last 10 years. If the criminal background report shows that an applicant has been convicted of any misdemeanor or felony within the past 10 years, then the Department of and DOPL must each approve authorization of the Contractor's employee based upon the nature of the criminal offense that resulted in the conviction and the criteria set forth in Utah Administrative Code R156-1-302 and R156-1-102(2) and (16).

(D) The Contractor shall conduct the criminal background report at its own cost.

17.2.3 Employee Compliance with State Law

(A) Each Contractor employee granted access to the Controlled Substance Database shall comply with the Utah Government Records Access and Management Act ("GRAMA"), Utah Code Ann §63G-2-101, et seq. and the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, et seq. Each employee must comply with the following:

(1) All information in the database falls within the definition of "record" in the GRAMA. All records in the database are records of DOPL. Pursuant to the provisions of GRAMA, records in the database are not public and access to those records is governed by the provisions of the Controlled Substance Database statute. (See Utah Code Ann. §§ 63G-2-201(3)(b); 63G-2-201(6)(a); and 58-37f-101 through 801.)

(B) The Contractor shall ensure that its employees who have access to the Controlled Substance Database understand their compliance responsibilities as described in Article 16.2.3(A) and shall provide any necessary training to its employees.

17.2.4 Limitation of Database Searches

Each Contractor employee who is authorized by the Department to access the Controlled Substance Database shall limit their searches of the Controlled Substance database to current Enrollees who are suspected of improperly obtaining or providing a controlled substance.

17.2.5 Search Submitted Directly to the Department of Commerce

(A) Contractor employees who have been given access to the Controlled Substance Database shall submit any request for database information directly to the Department of Commerce. The requests shall be in writing via letter, fax, or email.

(B) The Department of Commerce shall review the request for database information and may request additional information. If the request for database information is satisfactory, the Department of Commerce will conduct the database search and download the database information.

17.2.6 Employee Acknowledgement

(A) Any Contractor employee who has been authorized by the Department to access the Controlled Substance Database shall be required to sign an acknowledgement regarding their

access as required by the Department and the Utah Department of Commerce prior to gaining access to the Database. The acknowledgement shall include the language found in Article 16.2.7 which may be subject to change.

17.2.7 Language of Employee Acknowledgement

As a managed care organization (MCO) employee authorized to request information from the Utah Controlled Substance Database, I understand and acknowledge that I will comply with the following statutes:

(1) Utah Code Ann. § 58-37f-301(2)(f) provides that the database manager shall provide database information:

(a) in accordance with the written agreement entered into with the Department, and the Department of Health, authorized employees of a MCO, as defined in 42 C.F.R. 438, if:

(i) the MCO contracts with the Department of Health under the provisions of Section 26-18-405, and the contract includes provisions that:

(A) require an MCO employee who will have access to information from the database to submit to a criminal background check; and

(B) limit the authorized employee of the MCO to requesting either the Division or the Department of Health to conduct a search of the database regarding a specific Medicaid enrollee and to report the results of the search to the authorized employee; and

(ii) the information is requested by an authorized employee of the MCO in relation to a person who is enrolled in the CHIP program with the MCO, and the MCO suspects the person may be improperly obtaining or providing a controlled substance;

(2) Utah Code Ann. § 58-37f-601(1), which provides as follows:

Any person who knowingly and intentionally releases any information in the database or knowingly and intentionally releases any information obtained from other state or federal prescription monitoring programs by means of the database in violation of the limitations under Utah Code Ann. § 58-37f-601 Part 3, Access and Utilization, is guilty of a third degree felony.

(3) Utah Code Ann. § 58-37f-601(2), which provides as follows:

Any person who obtains or attempts to obtain information from the database or from any other state or federal prescription monitoring programs by means of the database by misrepresentation or fraud is guilty of a third degree felony.

(4) Utah Code Ann. § 58-37f-601(3), which provides, in part, as follows:

(a) a person may not knowingly and intentionally use, release, publish, or otherwise make available to any other person or entity any information obtained from the database or from any other state or federal prescription monitoring programs by means of the database for any purpose other than those specified in Utah Code Ann. § 58-37f-601 Part 3, Access and Utilization; and

(b) Each separate violation of this Subsection (3) is a third degree felony and is also subject to a civil penalty not to exceed \$5,000.

As an authorized MCO employee, I shall strictly limit my investigation and my request for database information to subjects who: (1) are enrolled in the Medicaid program with my managed care organization, (2) are suspected of improperly obtaining or providing a controlled substance, as specifically set forth in Utah Code Ann. § 58-37f-301(2)(e).

As an authorized MCO employee, I shall not release any database information to any unauthorized person, including persons within my MCO who are not authorized to view the information, employees of the Department of Health, or any law enforcement or prosecutorial agency. I acknowledge that database information shall not be used as evidence in any administrative, civil, or criminal litigation.

17.2.8 Employee Termination

The Contractor shall immediately notify the Department and the Utah Department of Commerce when any employee who has been granted access to the Controlled Substance database has terminated employment with the Contractor or who no longer requires access to the Controlled Substance Database as part of their job duties.

17.2.9 Termination of Access

(A) The Department or the Utah Department of Commerce may unilaterally terminate access of any authorized employee to the Controlled Substance Database at any time if the Department or DOPL determines that the authorized employee has violated any of the provisions set forth in the access agreement described in Article 16.2.5, any statute, or any administrative rule governing the Controlled Substance Database.

(B) Any decision to terminate access to the Controlled Substance Database may be reviewed by the Executive Director of the Utah Department of Commerce.

17.2.10 Hold Harmless

The Contractor shall hold the Department harmless from and against any claims, damages,

causes of action, losses, and expenses that arise out of any violation of the Utah Controlled Substance Database statute, Utah Code Ann. §58-37f-101, et seq. or its implementing regulations committed by the Contractor, its employees, or subcontractors.

17.3 Data Security Provisions

17.3.1 Duty of Confidentiality

The Contractor shall maintain the confidentiality of any Confidential Data that it receives from the Department or any other state or public office, which has been disclosed to the Contractor for the purpose of performance under this Contract. This includes any information contained in any database maintained by the State of Utah. This duty of confidentiality shall be ongoing and shall survive the term of this Contract.

17.3.2 Network Security

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

(B) For any network on which the Contractor stores or transmits Confidential Data, the Contractor shall maintain network security that conforms to one of the following:

- (1) Those standards which the State of Utah applies to its own network as found at <http://www.dts.utah.gov>;
- (2) current standards set forth and maintained by the National Institute of Standards and Technology; or
- (3) any industry accepted standards that is comparable to those described in 17.2.2(B)(1) or (2).

17.3.3 Data Security

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

- (1) Standards 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 are comparable to those described in 17.2.3(A)(1) or (2).

(B) The Contractor shall develop and use appropriate administrative, technical and physical security measures to preserve the confidentiality and integrity of all electronically maintained or

transmitted Confidential Data. These security measures include, but are not limited to, maintaining up-to-date anti-virus software, maintaining systems with current security updates, and controlled access to the physical location of the hardware itself.

17.3.4 Data Transmission

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

17.3.5 Data Storage

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

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

17.3.6 Data Re-Use

The Contractor shall ensure that any and all Confidential Data exchanged shall be used expressly and solely for the purposes of fulfilling this Contract and other purposes as required or permitted by law. Confidential Data shall not be distributed, repurposed or 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.

17.3.7 Notification of Confidential Data Breach

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

17.3.8 Confidentiality, Data Security, Subcontractors

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

17.3.9 Access to State of Utah Databases

(A) The Contractor shall maintain a log of all employees or Subcontractors who have access to any database maintained by the State of Utah or by the Department to whom the Department has given access.

(B) The Contractor shall notify the Department within two business days when an employee or subcontractor who has access to a database maintained by the Department or the State no longer requires access to the database.

(C) On a quarterly basis the Contractor shall provide to the Department a log of all employees who have access to a Department or State maintained database and in submitting that log to the Department, shall certify that the job duties of each employee named in the log requires that employee to have access to a Department-maintained database.

17.4 Health Information Technology Standards

The Contractor shall comply with the applicable requirements for health information technology (IT) standards as described in 45 CFR 170 Subpart B, and the Interoperability Standards Advisory (ISA), and shall work toward implementation of these requirements that become effective beginning July 1, 2021.

Attachment C – Covered Services, Limitations, Exclusions And Co-Payment Requirements

Article 1: Covered Services

The Contractor shall provide the following benefits to CHIP Enrollees in accordance with benefits as defined in the Utah Children's Health Insurance Program State Plan subject to the exclusions or limitations noted in this attachment. The Department reserves the right to interpret what is in the State Plan. CHIP covered services can only be limited through utilization criteria based on medical necessity. The Contractor shall provide at least the following benefits to CHIP Enrollees.

The Contractor is responsible to provide or arrange for all appropriate covered services on an emergency basis 24 hours each day, seven days a week. The Contractor is responsible for payment for all covered emergency services furnished by Non-Participating Providers.

1.1 Hospital Services

(A) Inpatient Hospital

Services furnished in a licensed, certified hospital.

(B) Outpatient Hospital

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital.

(C) Emergency Department Services

Emergency services provided to Enrollees in designated hospital emergency departments.

1.2 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. Includes surgery and anesthesia.

1.3 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.

Services include:

(A) Routine vision examinations and;

(B) One exam every 12 months.

1.4 Lab and Radiology Services

(A) Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this Contract must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number.

(B) Laboratories with certificates of waiver will 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.

1.5 Physical Therapy/ Occupational Therapy

Treatment and services provided by a licensed physical or occupational therapist. A physician must authorize treatment and services for physical or occupational therapy.

1.6 Hearing Services

(A) Screening services provided by a licensed medical professional/audiologist to test for any hearing loss. One exam every 12 months.

(B) Bilateral cochlear implants are covered up to a lifetime maximum of \$35,000. The surgery itself (facility, anesthesia, physician's fees, etc.) and the implant device apply to this limit. Aural rehabilitation related to an approved cochlear implantation is subject to speech therapy benefit limitations but does not apply to the maximum plan payment. Maintenance on the device, such as replacement batteries, is a covered service and does not apply to the maximum plan payment, whether or not the implant was performed while covered by CHIP.

1.7 Podiatry Services

Services provided by a licensed podiatrist.

1.8 End Stage Renal Disease – Dialysis

Treatment of end stage renal failure by dialysis. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.9 Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses and licensed practical nurses) in the Enrollee's home when the

Enrollee is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified Home Health Agency.

1.10 Speech Therapy

Services provided by a licensed speech language pathologist if therapy is to restore speech loss or to correct impairment if due to a congenital defect or an injury or sickness.

1.11 Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect to receive palliative care. Hospice care is to be rendered by a Medicare-certified hospice. Hospice services are available to clients without them forgoing any other service including curative treatment to which they are entitled under this contract. [Reference: Affordable Care Act, Section 2302, SMD # 10-018]

1.12 Durable Medical Equipment and Supplies

Equipment and appliances used to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. Durable medical equipment includes, but is not limited to, prosthetic devices.

1.13 Abortions and Sterilizations

These services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. Abortion services to unmarried minors must have written notification of the parent or legal guardian.

1.14 Organ Transplants

The following transplantations are covered for all Enrollees:

- (A) bone marrow
- (B) combined heart/lung
- (C) combined pancreas/kidney
- (D) cornea
- (E) heart

(F) kidney

(G) liver

(H) pancreas after kidney

(I) single or double lung

1.15 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

1.16 Transportation Services

Ambulance (ground and air) service for medical emergencies.

1.17 Preventive Services (Well-Child Care)

The Contractor shall provide to CHIP Enrollees preventive screening services, including routine physical examinations and immunizations.

The Contractor shall provide preventive services to all eligible children and young adults up to age 19 in accordance with the American Academy of Pediatrics (AAP) periodicity schedules.

The Contractor agrees to educate and encourage compliance with the AAP periodicity schedules. These efforts will include education 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 CHIP Enrollees.

1.18 Family Planning Services

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah law.

The following family planning services are not covered:

(A) Norplant

(B) Infertility drugs

(C) In-vitro fertilization

(D) Genetic counseling

1.19 Pharmacy Services

(A) Prescribed drugs and preparations provided in a licensed pharmacy. Over the counter (OTC) drugs are not covered. Prescriptions must be medically necessary and may be limited to generic medications where medically acceptable. The DEPARTMENT advisory board of medical professionals may establish an approved list of covered name brand drugs, or a formulary/approved list of drugs will be developed by the Contractor, reviewed and approved by the Department.

(B) Prospective drug utilization review at the point of sale and retrospective drug utilization review will be done by the Contractor or its pharmacy benefit manager.

1.20 Mental Health and Substance Use Disorder

(A) Inpatient and outpatient Mental Health and Substance Use Disorder services are covered. Medically necessary services from contracted hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are covered. Residential treatment is covered. The Contractor shall verify medical necessity after the first thirty days, and every thirty days thereafter.

(B) The Contractor shall assure that they and their network providers use age-appropriate validated behavioral health screening and assessment tools in primary care practice and shall provide education, training, and technical resources. This includes the cost of administering or purchasing the tools.

1.21 Medical and Surgical Services of a Dentist

Dental Services

Dental services are covered in the following limited circumstances:

(A) When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical provider whose primary practice is not dentistry or oral surgery.

(B) When the Contractor determines the following to be medically necessary:

- i. Maxillary and/or mandibular procedures;
- ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension; and
- iii. Orthographic Services.

(C) For repairs of physical damage to sound natural teeth, crowns, and the supporting structures surrounding teeth when:

- i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;
- ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and
- iii. Repairs are initiated within one year of the date of the accident.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

Unless stated otherwise above, services rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth are not covered.

Dental Anesthesia

See Article 2.17, Dental Anesthesia, for circumstances where dental anesthesia is covered.

1.22 High-Risk Prenatal Services

The Contractor must ensure that high-risk pregnant Enrollees receive an appropriate level of quality prenatal care that is coordinated, comprehensive and continuous either by direct service or referral to an appropriate provider or facility.

1.23 Services for Children with Special Needs

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all areas of need to be most effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

Therefore all children with special health care needs must have timely access to the following services:

- (A) Comprehensive evaluation for the condition.
- (B) Pediatric sub-specialty consultation and care appropriate to the condition.
- (C) Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.
- (D) Durable medical equipment appropriate for the condition.

(E) Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multi-specialty clinics, when medically necessary, for their disorder.

The definition of children with special health needs includes, but is not limited to, the following conditions:

1. Nervous System Defects such as
Spina Bifida*
Sacral Agenesis*
Hydrocephalus

2. Craniofacial Defects such as
Cleft Lip and Palate*
Treacher - Collins Syndrome

3. Complex Skeletal Defects such as
Arthrogryposis*
Osteogenesis Imperfecta*
Phocomelia*

4. Inborn Metabolic Disorders such as
Phenylketonuria*
Galactosemia*

5. Neuromotor Disabilities such as
Cerebral palsy*
Muscular Dystrophy*
Complex Seizure Disorders

6. Congenital Heart Defects

7. Genetic Disorders such as
Chromosome Disorders
Genetic Disorders

8. Chronic Illnesses such as
Cystic Fibrosis
Hemophilia
Rheumatoid Arthritis
Bronchopulmonary Dysplasia
Cancer

Diabetes
Nephritis
Immune Disorders

9. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

1.24 Facility Charges for Dental Procedures

The Contractor is responsible to pay for the cost of the facility when a member qualifies to receive dental anesthesia under Section 2.16.

1.25 Applied Behavior Analysis (ABA) Services

ABA services are covered for Enrollees with a valid diagnosis of Autism Spectrum Disorder (ASD).

(A) When an Enrollee is diagnosed by a clinician who under the scope of their licensure can render an ASD diagnoses the Enrollee must have access to the following services:

- (1) ASD Diagnostic Services;
- (2) ASD related physical, occupational and speech therapy; and
- (3) ASD related ABA services

(B) The Contractor is responsible to pay for the following ABA CPT codes:

- (1) 97151 Behavior and Functional Identification Assessment;
- (2) 97153 Adaptive Behavior Treatment by Protocol;
- (3) 97154 Group Adaptive Behavior Treatment by Protocol;
- (4) 97155 Adaptive Behavior Treatment with Protocol Modification;
- (5) 97156 Family Adaptive Behavior Treatment Guidance;
- (6) 97157 Multiple Family Adaptive Behavior Treatment Guidance; and
- (7) 97158 Adaptive Behavior Treatment Social Skills Group.

Article 2: Limitations and Exclusions

Unless otherwise noted in this attachment as specifically covered, the following Limitations and Exclusions apply.

2.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

- (A) When a physician has found that the abortion is necessary to save the life of the mother; or
- (B) Where the pregnancy resulted from an act of rape or incest.

2.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

2.3 Administrative Services/Charges

Services obtained for administrative purposes are not covered. Such administrative purposes include Services obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements. Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administration Code R590—192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

2.4 Allergy Tests/Treatments

2.4.1 Non Covered Allergy Tests:

- (A) Cytotoxic Test (Bryan's Test)
- (B) Leukocyte Histamine Release Test
- (C) Mediator Release Test (MRT)
- (D) Passive Cutaneous Transfer Test (P—K Test)
- (E) Provocative Conjunctival Test
- (F) Provocative Nasal Test

(G) Rebuck Skin Window Test

(H) Rinkel Test

(I) Subcutaneous Provocative Food and Chemical Test

(J) Sublingual Provocative Food and Chemical Test

2.4.2 Non Covered Allergy Treatments:

(A) Allergoids

(B) Autogenous urine immunization

(C) LEAP therapy

(D) Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.)

(E) Neutralization therapy

(F) Photo—inactivated extracts

(G) Polymerized extracts

(H) Oral desensitization/immunotherapy

2.5 Anesthesia

General anesthesia rendered in a Provider's office is not covered.

2.6 Attention—Deficit/Hyperactivity Disorder

Cognitive or behavioral therapies for the treatment of these disorders are not covered.

2.7 Applied Behavior Analysis (ABA)

All services not mentioned in Attachment C Article 1.25.

2.8 Bariatric Surgery

Surgery to facilitate weight loss is not covered. The reversal or revision of such procedures and Services required for the treatment of complications from such procedures are not covered. However, medical or surgical complications that can be reasonably attributed to such a surgery will be considered for coverage if they arise ten years or more after the surgery.

2.9 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

2.10 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital is not covered. This includes all Provider and/ or Facility charges related to the delivery.

2.11 Certain Cancer Therapies

The following cancer therapies are not covered:

(A) Neutron beam therapy

(B) Proton beam therapy

2.12 Claims After One Year

Generally, claims with a date of service over one year old should be denied by the plan. Exceptions to this general rule should be addressed by the plan's policy and in its procedures.

2.13 Chiropractic Services

Chiropractic Services are not a covered

2.14 Complementary and Alternative Medicine (CAM)

Complementary, alternative and nontraditional Services are not covered. Such Services include acupuncture, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography.

2.15 Complications

All Services provided or ordered to treat complications of a noncovered Service are not covered unless stated otherwise in this document.

2.16 Custodial Care

Custodial Care is not covered.

2.17 Dental Anesthesia

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at participating facilities when members meet the following criteria:

- (A) The member is developmentally delayed, regardless of the chronological age of the member.
- (B) The member, regardless of age, has a congenital cardiac or neurological condition and provides documentation that the dental anesthesia is needed to closely monitor the condition; or
- (C) The member is younger than five years of age and:
 - i. The proposed dental work involves three or more teeth;
 - ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and
 - iii. The proposed procedures are restoration or extraction for rampant decay.

2.18 Cardiac/Neurologic Conditions

Consideration of coverage will be given to members, regardless of age, with congenital cardiac or neurological conditions. The member must provide documentation describing that the need for dental anesthesia is due to an underlying medical condition and the associated requirement to closely monitor this condition.

Dental anesthesia for conditions such as ADHD, situational anxiety, or fear of dentists is not covered.

Note: Remember, general anesthesia rendered with an office surgery is not covered.

2.19 Dry Needling

Dry needling procedures are not covered.

2.20 Duplication of Coverage

The following are not covered:

- (A) Services for which the member has obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.
- (B) Services received by a Member incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

2.21 Experimental and/or Investigational Services

Experimental and/or Investigational Services are not covered. An Experimental and/or Investigational Service is a service for which one or more of the following apply:

- (A) It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- (B) It is the subject of a current investigational new drug or new device application on file with the FDA;
- (C) It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;
- (D) It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
- (E) If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

2.22 Eye Surgery, Refractive

Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

2.23 Fitness Training

Fitness training, conditioning, exercise equipment, and membership fees to a spa or health club are not covered.

2.24 Food Supplements

Except for Dietary Products as defined by the Contractor, food supplements and substitutes are not covered.

2.25 Gene Therapy

Gene therapy or gene-based therapies are not covered.

2.26 Habilitation Therapy Services

Services designed to create or establish function that was not previously present are not covered.

2.27 Hearing Aids

Except for cochlear implants, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, auditory brain implants, bone—anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sound recognition is not covered.

2.28 Home Health Aides

Services provided by a home health aide are not covered.

2.29 Immunizations

The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.

2.30 Noncovered Service in Conjunction with a Covered Service

When a noncovered Service is performed as part of the same operation or process as a Covered Service, only charges relating to the Covered Service will be considered. Allowed Amounts may be calculated and fairly apportioned to exclude any charges related to the noncovered Service.

2.31 Pain Management Services

The following Services are not covered:

- (A) Prolotherapy
- (B) Radiofrequency ablation of dorsal root ganglion
- (C) Acupuncture
- (D) IV pamidronate therapy for the treatment of reflex sympathetic dystrophy

2.32 Pervasive Developmental Disorder

Services for Pervasive Developmental Disorder are not covered.

2.33 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

- (A) Appetite suppressants and weight loss medications;
- (B) Certain off-label drug usage, unless the use has been approved by a Health Plan Medical Director or clinical pharmacist;
- (C) Compound drugs when alternative products are available commercially;
- (D) Cosmetic health and beauty aids;
- (E) Drugs purchased from Nonparticipating Providers over the Internet;
- (F) Flu symptom medications;
- (G) Drugs and medications purchased through a foreign pharmacy, unless approved by the Contractor.
- (H) Human growth hormone for the treatment of idiopathic short stature;
- (I) Infertility medications;
- (J) Medications not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval and/or DrugDex level IIa strength of recommendation, and National Comprehensive Cancer Network (NCCN) category 2A, if applicable.
- (K) Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;
- (L) Nicotine and smoking cessation medications, except in conjunction with a Contractor - sponsored smoking cessation program;
- (M) Over-the-counter (OTC) medications, except as approved by the Contractor;
- (N) Prescription Drugs used for cosmetic purposes;
- (O) Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;
- (P) Replacement of lost, stolen, or damaged drugs and medications;
- (Q) Sexual dysfunction medications and;
- (R) Travel-related medications, including preventive medication for the purpose of travel to other countries.

2.34 Reconstructive, Corrective, and Cosmetic Services

Services provided for the following reasons are not covered:

- (A) To improve form or appearance;
- (B) To correct a deformity, whether congenital or acquired, without restoring physical function;
- (C) To cope with psychological factors such as poor self-image or difficult social relations;
- (D) The service is rendered within 12 months of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of services (as specifically documented in the member's medical record) is initiated within the 12-month period;
- (E) To revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment;
- (F) Breast reduction (except according to Contractor criteria);
- (G) Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair;
- (H) Port wine stain treatment (except according to Contractor criteria);
- (I) Sclerotherapy of superficial varicose veins (spider veins);

2.35 Rehabilitation Therapy Services

The following are not covered:

- (A) Services for functional nervous disorders;
- (B) Vision rehabilitation therapy Services;
- (C) Speech therapy for developmental speech delay.

2.36 Related Provider Services

Services provided to a Member by a Provider who ordinarily resides in the same household as the Member are not covered.

2.37 Respite Care

Respite Care is not covered.

2.38 Sexual Dysfunction

Services related to sexual dysfunction are not covered.

2.39 Specialty Services

Coverage for specific specialty Services may be restricted to only those Providers who are board certified or have other formal training that is considered necessary to perform those Services.

2.40 Specific Services

The following Services are not covered:

- (A) Anodyne infrared device for any indication
- (B) Auditory brain implantation
- (C) Chronic intermittent insulin IV therapy/metabolic activation therapy
- (D) Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue
- (E) Computer-assisted interpretation of x-rays (except mammograms)
- (F) Extracorporeal shock wave therapy for musculoskeletal indications
- (G) Cryoablation therapy for plantar fasciitis and Morton's neuroma
- (H) Freestanding/home cervical traction
- (I) Home anticoagulation or hemoglobin A1C testing
- (J) Infrared light coagulation for the treatment of hemorrhoids
- (K) Interferential/neuromuscular stimulators
- (L) Intimal Media Thickness (IMT) testing to assess risk of coronary disease
- (M) Lovaas therapy
- (N) Magnetic Source Imaging (MSI)
- (O) Microprocessor controlled, computerized lower extremity limb prostheses
- (P) Mole mapping

(Q) Nonsurgical spinal decompression therapy (e. g. , VAX-D or DRS therapy)

(R) Nucleoplasty or other forms of percutaneous disc decompression

(S) Pressure Specified Sensory Device (PSSD) for neuropathy testing

(T) Prolotherapy

(U) Radiofrequency ablation for lateral epicondylitis

(V) Radiofrequency ablation of the dorsal root ganglion

(W) Secretin infusion therapy for the treatment of autism

(X) Virtual colonoscopy

(Y) Whole body scanning

2.41 Telephone/E-mail Consultations

Charges for Provider telephone, e-mail, or other electronic consultations are not covered.

2.42 Terrorism or Nuclear Release

Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

2.43 Travel-Related Expenses

Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

2.44 War

Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country.

2.45 Orthotics and Other Corrective Appliances for the Foot

Not covered unless they are part of a lower foot brace, and they are prescribed as part of a specific treatment associated with recent, related surgery.

2.46 General Exclusions

(A) Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP.

(B) Charges for educational material, literature or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illnesses such as diabetes.

(C) Charges for services primarily for convenience, contentment or other non-therapeutic purpose.

(D) Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.

(E) Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.

(F) Charges which the insured is not, in the absence of coverage, legally obligated to pay.

(G) Charges for services, treatments or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.

(H) Charges for services, treatments or supplies received as a result of an act of war occurring when the insured is covered by CHIP.

(I) Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which is payable under workman's compensation or employer's liability laws.

(J) Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.

(K) Charges made for completion or submission of insurance forms.

(L) Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.

(M) Shipping, handling, or finance charges.

(N) Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.

(O) Charges for expenses in connection with appointments scheduled and not kept.

(P) Charges for telephone calls or consultations.

Article 3: Co-Insurance and Co-Payment Requirements for CHIP Plan B

(PLAN B)

3.1 Hospital Services (inpatient, outpatient and emergency department)

\$150 co-payment, after deductible for allowable inpatient hospital services
Plan pays 95%, after deductible for ambulatory surgical and outpatient hospital services
Plan pays 95% for surgeon and anesthesiologist services
\$10 co-payment for non-emergency use of emergency room

For all other hospital services
\$5 co-payment per visit

3.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

\$5 co-payment per visit

No co-payment for well-baby care, well-child care and immunizations

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

3.3 Laboratory and X-Ray Services

For laboratory services \$350 and under (of allowable charges)*: No co-payment
For laboratory services above \$350 (of allowable charges)**: Co-insurance, 5% of allowed amount after deductible

For X-ray services \$350 and under (of allowable charges)*: No co-payment
For X-ray services above \$350 (of allowable charges)**: Co-insurance, 5% of allowed amount after deductible

Instead of by dollar amount, the Contractor may choose to group these diagnostic tests as Major** (corresponding to the above \$350 co-pay category) and Minor *(corresponding to the \$350 and under category) and have co-payment schedules reflecting those same categorizations. These groups shall be closely based on allowable charges for (1) those \$350 and under and (2) over \$350.

3.4 Prescription Drugs

For generic drugs on an approved list: \$5 co-payment per prescription
For all other drugs: Co-insurance, 5% of allowed amount

3.5 Vision Screening Services

\$5 co-payment, limit of one exam every 12 months.

3.6 Hearing Screening Services

\$5 co-payment, limit of one exam every 12 months.

3.7 Durable Medical Equipment and Supplies

Co-insurance, 5% of allowed amount after deductible

3.8 Mental Health and Substance Use Disorder Services

3.8.1 Inpatient:

\$150 co-payment, after deductible

3.8.2 Outpatient, Office Visit and Urgent Care:

\$0 co-payment per visit

3.8.3 Residential Treatment:

\$0 co-payment.

3.9 Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder (ASD)

\$0 co-payment

109 Ambulance - Ground and Air

Co-insurance, 5% of allowed amount after deductible

3.11 Home Health and Hospice Care

Co-insurance, 5% of allowed amount after deductible

3.12 Deductible

Plan B enrollees are required to pay \$40 per family per year.

3.13 Pre-existing Condition Waiting Period

No waiting period

3.14 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the Department. Upon request, the Contractor will provide the Department with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the Department, the Contractor will switch the family to a no out-of-pocket payment (exempt) option, will reimburse the family for any excess amount paid above 5% and will mail new identification cards to the family.

NOTE: The allowed amount is (1) the contract rate that the Contractor has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

Article 4: Co-Insurance and Co-Payment Requirements for CHIP Plan C

(PLAN C)

4.1 Hospital Services (inpatient, outpatient and emergency department)

Co-insurance, 20% of allowed amount after deductible, for inpatient, outpatient, and ambulatory surgical services

Plan pays 80% for surgeon and anesthesiologist services, after deductible

\$300 co-payment for each participating emergency department visit, after deductible

\$300 co-payment for each non-participating emergency department visit, after deductible

4.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

For physician visits \$25 co-payment per visit

Therapy visits

(Physical, occupational and speech): \$40 co-payment per visit after deductible

For all other outpatient office visits

Including specialists and urgent care: \$40 co-payment per visit

No co-payment for well-baby care, well-child care and immunizations

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

4.3 Laboratory and X-Ray Services

For laboratory services \$350 and under (of allowable charges)*: No co-payment

For laboratory services above \$350 (of allowable charges)**: Co-insurance, 20% of allowed amount, after deductible

For X-ray services \$350 and under (of allowable charges)*: No co-payment

For X-ray services above \$350 (of allowable charges)**: Co-insurance, 20% of allowed amount, after deductible

Instead of by dollar amount, the Contractor may choose to group these diagnostic tests as Major** (corresponding to the above \$350 co-pay category) and Minor *(corresponding to the \$350 and under category) and have co-payment schedules reflecting those same categorizations. These groups shall be closely based on allowable charges for (1) those \$350 and under and (2) over \$350.

4.4 Prescription Drugs

For generic drugs on an approved list: \$15 co-payment per prescription

For brand name drugs on an approved list: Co-insurance, 25% of allowed amount

For drugs not on an approved list: Co-insurance, 50% of allowed amount

4.5 Vision Screening Services

\$25 co-payment, limit of one exam every 12 months

4.6 Hearing Screening Services

\$25 co-payment, limit of one exam every 12 months

4.7 Durable Medical Equipment and Supplies

Co-insurance, 20% of allowed amount after deductible

4.8 Mental Health & Substance Use Disorder

4.8.1 Inpatient Facility:

Co-insurance, 20% of allowed amount after deductible

4.8.2 Outpatient, Office Visit and Urgent Care:

\$0 co-payment per visit

4.8.3 Residential Treatment:

\$0 co-payment

4.9 Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder (ASD)

\$0 co-payment

4.10 Ambulance - Ground and Air

Co-insurance, 20% of allowed amount after deductible

4.11 Home Health and Hospice Care

Co-insurance, 20% of allowed amount after deductible

4.12 Deductible

Plan C enrollees are required to pay \$500 per person / \$1,500 per family.

4.13 Pre-existing Condition Waiting Period

No waiting period

4.14 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the Department. Upon request, the Contractor will provide the Department with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the Department, the Contractor will switch the family to a no out-of-pocket payment (exempt) option, will reimburse the family for any excess amount paid above 5%, and will mail new identification cards to the family.

NOTE: The allowed amount is (1) the contract rate that the Contractor has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

Article 5: Requirements for CHIP American Indian/Alaska Native Policy

5.1 Hospital Services (inpatient, outpatient and emergency department)

No co-payment, plan pays 100%

Plan pays 100% for surgeon, anesthesiologist, ambulatory surgical, outpatient hospital, and hospital inpatient physician visits

5.2 Outpatient Office Visits or Urgent Care Center Visits

This includes physician, physician-related, physical and occupational therapy, urgent care, speech therapy, and podiatry visits.

No co-payment, plan pays 100%

No co-payment for immunizations and well child exams

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

5.3 Laboratory and X-Ray Services

Plan pays 100%

5.4 Prescription Drugs

No co-pay for prescriptions

5.5 Vision Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

5.6 Hearing Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

5.7 Durable Medical Equipment and Supplies

Plan pays 100%

5.8 Mental Health and Substance Use Disorder

5.8.1 Inpatient, Outpatient Facility and Emergency Room:

Plan pays 100%

5.8.2 Office Visit:

Plan pays 100%

5.8.3 Residential Treatment:

Plan pays 100%

5.9 Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder (ASD)

Plan pays 100%

5.10 Ambulance - Ground and Air

Plan pays 100%

5.11 Home Health and Hospice Care

Plan pays 100%

5.12 Pre-existing Condition Waiting Period

No waiting period

5.13 Out-of-Pocket Maximum

Not applicable. There are no out-of-pocket expenses for Native Americans.

NOTE: The allowed amount is (1) the contract rate that the Health Plan has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

Article 6: Contract Year Basis for Benefits

7.1 Benefits – Contract Year Basis

Benefits are administered on a contract year basis. The Health Plan is not responsible to administer run-in claims from the prior Health Plan. The 5% out-of-pocket maximum is calculated based on the date the Enrollee's eligibility begins and the 5% maximum starts over at each eligibility recertification period.

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 which oversees the QAPIP, a designated senior official responsible for administration of the program, an interdisciplinary quality assessment and performance improvement committee that has the authority to report its findings and recommendations for improvement to the Contractor's executive director, and a mechanism for ongoing communication and collaboration among the executive director, the policymaking body, and other functional areas of the organization.

(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) Conduct Performance Improvement Projects (PIPs) in accordance with Article 1.1.4;
- (2) Collect and submit performance measurement data in accordance with Article 1.1.5;
- (3) Have in effect mechanisms to detect both underutilization and overutilization of services;
- (4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs as defined by the Department in the quality strategy under 42 CFR 438.30; and

1.3 QAPIP Plan and Submission

(A) The Contractor shall maintain a written QAPIP plan that addresses Articles 1.1.1 and 1.1.2.

(B) The Contractor shall submit its written QAPIP plan to the Department by February 1st or mutually agreed upon date in writing of each year.

(C) The Contractor shall submit the following QAPIP documents using the templates provided by the Department

- (1) QAPIP Program Description
- (2) QAPIP Work Plan
- (3) QAPIP Work Plan Evaluation

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 that 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 1.1.4(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 topic to the Department for approval using a format specified by the Department.

(D) The Contractor shall report the status and results of each project, 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) Maintain each performance measure specified in Article 2.3 at or above the national average;

- (2) Measure and report to the Department its performance, using standard measures required by the Department and/or CMS;
- (3) Submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or
- (4) 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 R428-13-1, *et seq*; and
- (2) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data to OHCS as set forth in Utah Administrative Code R428-12-12-1 *et seq*.

(C) Data, calculations for HEDIS and CAHPS, and results of standard measures shall include all CHIP 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 Measures Table

Population/ Condition	Preventive Services	Chronic Care	Acute Care	Access	Satisfaction
Newborn / Infant Care	CIS: Childhood Status: Combo 3	N/A	N/A	N/A	N/A

	W30: Well-Child Visits in the first 30 months of life				
Pediatric Care	IMA: Immunizations for Adolescents Combo 2 WCV: Child and Adolescent Well Care Visits for the age stratifications • 3-11 years • 12-18 years • Total WCC: Weight Assessment and Counseling - BMI Assessment for Children/Adolescents	N/A	URI: Appropriate Treatment for Children with Upper Respiratory Infection	CAHPS: Getting Needed Care; Getting Care Quickly; Customer Service; How Well Doctors Communicate	CAHPS: Health Care; Health Plan; Personal Doctor; Specialist
Adult Care	BCS: Breast Cancer Screening CCS: Cervical Cancer Screening AAP: Access to Amb. Care (Total)	CDC-D: Diabetes: A1c Testing CDC-G: Diabetes: Eye Exam CBP: controlling High Blood Pressure	LBP: Use of Imaging for Low Back Pain AMM: Antidepressant Medication Management - Acute Phase	CAHPS: Getting Needed Care; Getting Care Quickly; Customer Service; How Well Doctors Communicate	CAHPS: Health Care; Health Plan; Personal Doctor; Specialist

2.3 Quality Measure Corrective Actions

In the event that the Contractor's quality measure performance is not at or above the national average as required by this Article, the Contractor may be subject to the corrective actions found in Article 14 of Attachment B.

Article 3: External Quality Review

3.1 External Quality Review, Generally

(A) Pursuant to 42 CFR 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 requirement 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 Participating Providers.

(D) On-Site EQRs shall be performed during hours agreed upon by the Department and the Contractor.

(E) The Contractor shall assure adequate work space, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(F) The Contractor shall assign appropriate staff to assist during on-site EQRs.

(G) The Department and EQRO agree to accept electronic versions of documents where reasonable and work cooperatively with the Contractor to reduce administrative costs.

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: Risk Based Contract

1.1 Contract Classification

- (A) This Contract is classified as a Risk Contract.
- (B) The Contractor shall provide all services required by this Contract and the Capitation Payments made by the Department 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 CHIP-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. In the event of a change in Capitation Rates pursuant to a loss of funding, if the Contractor determines that the new rates are unacceptable, the Contractor may terminate this Contract after it provides 60 days

written notice of intent to terminate to the Department. If the Contractor elects to terminate the Contract pursuant to this Article 2.1(B) this shall not be considered a default under the Contract.

2.2 Capitation Rates

(A) The Department shall pay the Contractor:

July 1, 2021 - June 30, 2022		
Rate Cell	Description	Capitation Rate
B1	Age < 1; CHIP B	873.16
B2	Age 1-5; CHIP B	154.04
B3	Age 6-11; CHIP B	162.57
B4	Age 12-19; CHIP B	236.53
N1	Age < 1; Native American CHIP B	873.16
N2	Age 1-5; Native American CHIP B	154.04
N3	Age 6-11; Native American CHIP B	162.57
N4	Age 12-19; Native American CHIP B	236.53
C1	Age < 1; CHIP C	873.16
C2	Age 1-5; CHIP C	154.04
C3	Age 6-11; CHIP C	162.57
C4	Age 12-19; CHIP C	236.53
N5	Age < 1; Native American CHIP C	873.16
N6	Age 1-5; Native American CHIP C	154.04
N7	Age 6-11; Native American CHIP C	162.57
N8	Age 12-19; Native American CHIP C	236.53

(B) The final capitation rates are identified and developed and payment is made in accordance with 42 CFR 438.3(c), and consistent with actuarially sound principles as defined in 42 CFR 457.10.

2.3 Payment Procedures

(A) The Department shall make payments to the Contractor through its Medicaid Management Information System (MMIS) for all Enrollees under this Contract.

(B) Unless a sanction provision found in Attachment B applies, the Department shall pay the contractor the Capitation Rates designated in Section 2.2 of this Attachment E for all current Enrollees listed in the Department's 820 Enrollment report.

(C) On a weekly basis, the Department shall provide the Contractor with the following reports:

(1) an 820 Enrollment Report that includes identifying information on all Enrollees for which the Department has paid a Capitation Rate; and

(2) an 820 Enrollment Summary report that contains summary aggregate information of the count of Enrollees by month and Capitation Rate Cell.

2.4 Payment Adjustments

(A) If the Contractor believes an error in capitation payment has been made by the Department, the Contractor shall notify the Department, in writing. The Contractor shall supply supporting documentation for the Department's review. If appropriate, the Department shall adjust the Contractor's payment.

(B) The Department shall automatically adjust Capitation Rates when an Enrollee's aid category is changed retroactively. This information will be transmitted to the Contractor via the Eligibility Transmission.