

## **NOTICE**

This Attachment B of the model Contract is a first draft of the risk-based Medicaid HMO Contract. This Contract is being provided as a courtesy to you as a starting point for the parties to begin discussing the technical requirements involved in implementing the risk-based Medicaid HMO model.

This Contract will undergo go additional changes prior to it becoming finalized. Nothing in this contract shall be binding on the Division or on any Health Plan until the contract is finalized.

## **Article 1 Introductory Provisions**

### **1.1 Parties**

This contract is between the State of Utah, acting by and through its Department of Health hereinafter referred to as “DOH” or “Department” and **@Name of Contractor**, hereinafter referred to as “Contractor.” Together, the Department and Contractor shall be referred to as the “Parties.”

### **1.2 Notices**

Any notices that are permitted or required under this Contract shall be in writing and shall be transmitted through either:

- (a) Certified or registered United States mail, return receipt requested;
- (b) Personal delivery;
- (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:

@Address

@Address

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 Effective Date and Duration**

This contract shall be effective on January 1, 2013. This contract shall automatically terminate on June 30, 2016. The parties agree to meet prior to the end date of this contract to discuss terms and conditions that may be incorporated into future contracts. The effective date and duration of the contract may change subject to the Contract Termination Provisions found in Article 15.

## **1.4 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 includes all Utah Counties. The Contractor must provide adequate assurances and supporting documentation that the Contractor has the capacity to service the expected enrollment in the county in the state.

### **1.4.1 Reduction of Service Area**

If the Contractor reduces the service area it must notify the Department 90 days prior to the reduction and notify enrollees 60 days prior to the reduction. Notice to enrollees must be approved of in advance by the Department.

### **1.4.2 Residency in Service Area**

The Department has sole discretion to determine whether an enrollee resides in a particular service area.

## **ARTICLE 2: Definitions**

### **2.1 Contract Definitions**

#### **2.1.1 Definitions**

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

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

**Action** means:

1. the denial or limited authorization of a requested service, including the type or level of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service and the denial could result in the Enrollee liable for payment;
4. the failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times (see Article X, Contractor Assurances, Section E., Access, Subsection 4.e., Waiting Time Benchmarks); or
5. the failure of the CONTRACTOR to act within the time frames established for resolution

and notification of Grievances and Appeals.

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

**Appeal** means a request for review of an Action taken by the CONTRACTOR.

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

**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.

**BMHC** means the Bureau of Managed Health Care, Division of Medicaid and Health Financing, Utah Department of Health.

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

**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 Enrollee receives services during the period covered by the payment.

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

**CHEC Enrollee** means an Enrollee under the age of 21 who is eligible to receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services in accordance with 42 CFR Part 441, Subpart B.

**CHEC Program** or Child Health Evaluation and Care program means Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B. (See Attachment C, Covered Services, T.)

**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.

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

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

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

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

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

**Department** means the Division of Medicaid and Health Financing in the Department of Health that is responsible for the administration of the Utah Medicaid program.

**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.

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

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

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

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

3. serious dysfunction of any bodily organ or part.

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

**Encounter** means an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed fee-for-service under the Utah Medicaid Program.

**Encounter Data** means the compilation of data elements, as specified by the DEPARTMENT, identifying an Encounter that includes information similar to that required in a claim for fee-for-service payment under the Utah Medicaid Program.

**Enrollee** means any Medicaid Eligible Individual whose name appears on the DEPARTMENT's Eligibility Transmission (that is sent to the CONTRACTOR) as enrolled in this 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 II.

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

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

**Family Member** means all Medicaid Eligible Individuals who are members of the same family living at home.

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

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

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

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

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person including any act that constitutes fraud under applicable Federal or State law. Under Utah Code Ann. §63J-41-102(5), Fraud means intentional or knowing: (a) deception, misrepresentation, or up coding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or (b) a violation of a provision of Utah Code Ann. §§ 26-20-3 through 26-20-7.

**Grievance** means an expression of dissatisfaction about any matter other than an Action (as defined in this Article I). Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of providers, employees, etc., failure to respect the Enrollee's rights, denial of a request for expedited resolution of an Appeal, or extension of the timeframe for making standard authorization decisions.

**Grievance Process** means the CONTRACTOR's process for handling Grievances that complies with the requirements including, but not limited to, the procedural steps for an Enrollee to file a Grievance, the process for disposition of a Grievance, and the timing and manner of required notifications.

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

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

**Health 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 health care services to a specific group of Medicaid Eligible Individuals.

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

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

**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** 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 to also meet the following conditions: (i) Makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

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

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

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

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

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

**Medically Necessary** means any medical service that is (1) reasonably calculated to prevent, diagnose, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause

deformity or malfunction, or threaten to cause a handicap; and (2) there is no equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the DEPARTMENT upon request. **For CHEC Enrollees**, Medically Necessary means preventive screening services and other medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions, even if the services are not included in the Utah State Medicaid Plan.

**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.

**Non-Traditional Medicaid Plan** means the reduced benefit plan provided to Medicaid eligibles age 19 through 64 who:

1. are not blind, disabled or pregnant;
2. are in a Medically Needy aid category and are not blind, disabled or pregnant; or
3. are in a Transitional Medicaid aid category.

Non-Traditional Medicaid Plan Enrollees are in the 1115 Demonstration for the Primary Care Network of Utah demonstration waiver. These individuals' Medicaid cards specify they are in the Non-Traditional Medicaid Plan. Services covered under this reduced benefit plan are similar to the Traditional Medicaid Plan with some limitations and exclusions.

**Notice of Action** means written notification to an Enrollee and written or verbal notification to a provider when applicable, of an Action that will be taken by the CONTRACTOR.

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

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

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

1. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

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.

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

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

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

**Prepaid Mental Health Plan or PMHP** means the DEPARTMENT's mental health freedom-of-choice waiver approved by CMS that allows the DEPARTMENT to require Medicaid Eligible Individuals in certain counties of the State to obtain Covered Services from specified contractors.

**Primary Care** 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 Medicaid recipients.

**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 any individual or entity (e.g., hospital, home health agency, etc.) 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 has a contractual agreement with the CONTRACTOR to provide health care services to Enrollees.

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

**Restriction Program** means the federally mandated program (42 CFR 431.54(e)) for Medicaid Eligible Individuals who over-utilize Medicaid services. If the DEPARTMENT in conjunction with the CONTRACTOR finds that an Enrollee has utilized Medicaid services at a frequency or amount that is not Medically Necessary, as determined in accordance with utilization guidelines adopted by the DEPARTMENT, the DEPARTMENT may place the Enrollee under the Restriction Program for a reasonable period of time to obtain Medicaid services from designated providers only.

**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 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 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, for purposes of Article 6 of this Contract, (1) an individual, agency, or organization to which the CONTRACTOR has contracted or delegated some of its management functions or responsibilities of providing medical care to its Enrollees; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement,

purchase order, or leases (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement (i.e., this Contract).

**Suspended** means, for purposes of Article 6 of this Contract, that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

**Traditional Medicaid Plan** means the scope of services contained in the State Plan provided to Medicaid Eligible Individuals who fall under one of the following eligibility groups:

1. Section 1931 children and related poverty level populations under age 19;
2. Section 1931 pregnant women;
3. blind or disabled children and related populations;
4. blind or disabled adults and related populations under age 65;
5. aged adults age 65 and older and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);
6. children in Foster Care;
7. individuals who qualify for Medicaid by paying a spenddown and are under age 19; or
8. individuals who qualify for Medicaid by paying a spenddown and are also blind or disabled.

These Enrollees' Medicaid cards specify they are in the Traditional Medicaid Plan.

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

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

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

## **ARTICLE 3: Enrollment Services**

### **3.1 Marketing Activities**

The Contractor, its employees, affiliated providers, agents, or subcontractors may not conduct direct or indirect marketing.

#### **3.1.1 Prohibited Marketing Activities**

(A) Contractor, its employees, affiliated 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.

(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**

Contractor agrees to the following Marketing Responsibilities:

### **3.2.1 Policies and Procedures**

The Contractor shall maintain policies and procedures related to marketing that ensure compliance with the requirements described in this section.

### **3.2.2 Department Approval**

All marketing materials must be reviewed and have the approval of the Department Prior to distribution.

### **3.2.3 Specify Methods**

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

### **3.2.4 Distribution of Marketing Materials**

The Contractor shall distribute Marketing materials in all service areas the Contractor serves.

### **3.2.5 Marketing Activities Prohibited**

The Department has determined that no marketing activities specifically directed at potential Medicaid enrollees will be allowed under this contract.

## **3.3 Enrollment Process**

The Contractor shall have policies and procedures related to Enrollment that shall ensure compliance with the requirements of this section.

### **3.3.1 Enrollee Choice**

(A) The Department shall determine eligibility for enrollment and will offer potential enrollees a choice among all health plans available in the service area.

(B) The Department will inform potential enrollees of Medicaid Benefits.

(C) The Medicaid client'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. This initiates the action to send an advance notification to the Contractor.

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

### **3.3.2 Period of Enrollment**

(A) Each enrollee will be enrolled for either the period of this contract, the period of Medicaid eligibility, or until such persons disenrolls or is disenrolled, whichever is earlier.

(B) Until the Department notifies the Contractor that an Enrollee is no longer Medicaid eligible, the Contractor may assume that the Enrollee continues to be eligible. However, Contractor is responsible for verifying enrollment and the Department is not responsible for any losses the Contractor may incur if the Contractor provides services to enrollee who is no longer eligible.

(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 Contract.

### **3.3.3 Open Enrollment**

The Contractor shall have a continuous open enrollment period. 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 Prohibitions Against Conditions on Enrollment**

(A) Contractor must accept eligible enrollees without restrictions unless such restriction is authorized by the Department.

(B) Contractor and Department may not pre-screen or select potential enrollees on the basis of pre-existing health problems.

(C) Contractor shall not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(D) 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**

(A) Each Medicaid Eligible Individual can be enrolled or disenrolled from the 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 informally advise the Contractor of the anticipated changes. The Contractor shall have the opportunity to make comments and provide input on the changes. The Contractor will be bound by the changes in enrollment procedures.

## **3.4 Eligibility Transmission**

### **3.4.1 Eligibility Transmission, Generally**

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

(B) Critical Fields found in the Eligibility Transmission shall include: enrollee's case number, case name, eREP identification number, name, date of birth, date of death, social security number, gender, prevalent language, race, Capitation Rate Cell, pregnancy indicator, co-payment/coinsurance indicators, eligibility start date, third party liability coverage, county, address, phone number, and if applicable, the enrollee's provider under the Restriction Program.

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

(D) The appearance of an individual's name on the 834 File, other than a deleted enrollee, shall be evidence to the Contractor that the Department has determined that the individual is enrolled in the Health Plan and qualifies for Medical Assistance under Medicaid Tile XIX. In the event of any error in the 834 file, the Department shall not be responsible to Contractor for any losses the Contractor may incur if the Contractor provides services to enrollee who is no longer eligible.

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

### **3.4.2 Eligibility Transmission, Specific Types of Enrollees**

For purposes of the Eligibility Transmission the following designations apply:

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

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

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

(D) Terminated Enrollees are individuals who are no longer eligible for Medicaid, were disenrolled from the Health Plan, or had their premium retracted.

### **3.4.3 Eligibility File, Contractor Responsibilities**

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

## **3.5 Member Orientation**

### **3.5.1 Initial Contact—General Orientation**

(A) The Contractor shall make a good faith effort to ensure that each Enrollee or Enrollee's family or guardian receives the Contractor's Member Handbook.

(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 Contractor's Health Plan. Contractor shall maintain written or electronic records of such initial contact.

(1) If the Contractor's representative cannot contact the Enrollee within 10 working days or at all, the Contractor's representative shall document its efforts to contact 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 in writing and those attempts have been unsuccessful.

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

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

(1) Specific written and oral instructions on the use of the Contractor's covered services and procedures;

(2) Availability and accessibility of all Covered Services, including the availability of family planning services and that the Enrollee may obtain family planning services from Medicaid Providers other than providers affiliated with the Contractor;

(3) the Rights and Responsibilities of the Enrollee under the Health Plan, including the right to file a Grievance and how to file a Grievance;

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

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

### **3.5.2 Initial Contact--Identification of Enrollees with Special Health Care Needs**

(A) The Contractor shall establish a policy which shall be used by Contractor's representative during the initial contact to identify children and adults 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's individual with knowledge of coordination of care, case management services, and other services necessary for such Enrollees. The CONTRACTOR's individual with knowledge of coordination of care for Enrollees With Special Health Care Needs shall make a good faith effort to contact such Enrollees within ten working days after identification to begin coordination of health care needs, if 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 Enrollees Receiving Out-of-Plan Care Prior to Orientation**

(A) If the Enrollee receives covered services by an out-of-plan provider after the first day of the month in which the enrollee's enrollment became effective, the Contractor and Department shall determine if an Enrollee could have reasonably known that provider was out-of-network. The Enrollee will be deemed to not reasonably have known that a provider was out-of-network if:

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

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

## **3.6 Member Education**

### **3.6.1 Enrollee Information Requirements—Generally**

(A) The contractor shall write all Enrollee and Potential Enrollee informational, instruction, and educational materials, including the Contractor's member handbook in a manner that may be easily understood at a sixth grade reading level.

(B) Once a year, the Contractor shall notify all Enrollees of their right to request and obtain the Contractor's member handbook.

### **3.6.2 Enrollee Information Requirements—Prevalent Language**

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

(B) The Contractor shall make available all written Enrollee informational and instructional materials, including the member handbook, in the prevalent non-English languages. Written

materials include vital documents such as applications, consent forms, release of information forms, letters containing important information, etc.

### **3.6.3 Enrollee Information Requirements—Alternative Formats**

(A) The Contractor shall make Enrollee informational and instructional materials, including the member handbook, available in alternative formats that take into consideration the special needs of those who are visually limited or have a limited reading proficiency. Such alternative formats might include audio or video recordings.

### **3.6.4 Member Handbook**

(A) The Contractor shall submit its member handbook to the Department for review and approval prior to general distribution. The Department shall notify the Contractor in writing of its approval or disapproval within thirty working days after receiving the member 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 handbook, the Contractor shall update the member handbook and submit a draft to the Department for review and approval before distribution to enrollees. The Department shall notify the Contractor in writing of its approval or disapproval within thirty working days after receiving the member handbook unless the Department and Contractor agree to another timeframe. If the Department does not respond within the agreed upon time frame, the Contractor may deem such materials approved by the Department.

(C) At minimum, the member handbook shall explain in clear terms the following information:

(1) The amount, duration, and scope of benefits provided by the Contractor described in sufficient detail to ensure that Enrollees understand scope of service and the benefits to which they are entitled.

(2) Contractor's procedures for obtaining benefits, including service authorization requirements;

(3) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;

(4) The extent to which, and how, after-hours emergency coverage is provided including:

(i) what constitutes an Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services with reference to definitions in 42 CFR 438.114(a);

- (ii) the fact that prior authorization is not required for Emergency Services;
  - (iii) the process and procedures for obtaining Emergency Services including use of the 911 telephone system or its local equivalent;
  - (iv) the location of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under Contract; and
  - (v) the fact that the Enrollee has the right to use any hospital or other setting for emergency care.
- (5) The Post-Stabilization Care Services rules set forth at 42 CFR 422.113(c);
- (6) Contractor's Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- (7) Description of Enrollee cost-sharing requirements, where applicable;
- (8) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided.
- (9) A statement that the Contractor does not discriminate against any Enrollee on the basis of race, color, national origin, disability, sex, religion, or age in admission, treatment or participation in its programs, services, and activities;
- (10) The importance of establishing a primary care relationship with an affiliated provider, and processes for selecting or changing Primary Care Providers;
- (11) The phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or Grievance alleging violations of the nondiscrimination policy;
- (12) Information on the availability of oral interpretation, including the fact that it is available for any language and that written information is available in prevalent languages, and includes a statement on how to access these services;
- (13) Information on the availability of written materials in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency, and a statement on how to access these formats;
- (14) Names, locations, telephone numbers of, and non-English languages spoken by, current contracted Providers in the Enrollee's service area, including identification of Providers that are not accepting new patients. This includes, at a minimum, information

on Primary Care Providers, specialists, and hospitals;

(15) Any restrictions on the Enrollee's freedom of choice among network Providers;

(16) Enrollee rights and protections, as specified in Article 6 of this Contract;

(17) Information on Grievance, Appeal, and State fair hearing procedures and timeframes as provided in 42 CFR 438.400 through 42 CFR 438.424, in a DEPARTMENT-approved description that shall include the following:

- (i) the Enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;
- (ii) the Enrollee's right to file Grievances and Appeals;
- (iii) the requirements and timeframes for filing a Grievance or Appeal;
- (iv) the availability of assistance in the filing process;
- (v) the toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone; and
- (vi) the fact that, when requested by the Enrollee:
  - (a) disputed services will continue if the Enrollee files an Appeal or a request for a State fair hearing within the timeframes specified for filing, and
  - (b) The Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee.

(18) Information to adult Enrollees on Advance Directives policies, including a description of applicable State law as set forth in 42 CFR 422.128;

(19) A statement that additional information is available upon an Enrollee's request regarding structure and operation of the Contractor, including information on:

- (i) the Contractor's policy for selection of providers (staff and subcontractors) and what is required of them; and
- (ii) that information is available on request regarding the Contractor's Physician Incentive Plan, if any.

(20) A description of the circumstances in which the Enrollee may be responsible for payment including when:

(i) the enrollee has given advanced written consent to the provider to pay for and obtain a service that is not a benefit of the plan;

(ii) the enrollee has given advanced written consent to the provider to pay for the services and has obtained a services not authorized by the Contractor;

(iii) the Enrollee has had an appeal or state fair hearing decisions adverse to the Enrollee and disputed services were continued during the Appeal or State fair hearing process at the Enrollee's request; and

(iv) the enrollee has become ineligible for Medicaid for any portion of the time period during which services were provided.

(22) Description of Member Services function; and

(21) Reasons the Contractor may initiate disenrollment of an Enrollee.

(A) The Contractor shall notify the Department when it makes changes to the member handbook at least 90 days prior to the changes taking effect. If the Department deems the changes being made to the member handbook to be "significant" the Contractor shall give each enrollee written notice of the change at least 30 days prior to the intended effective date of the change. The Department agrees to notify the Contractor of information deemed to be "significant" at least 60 calendar days prior to the intended effective date.

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

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

### **3.7 Disenrollment Initiated by Enrollees**

#### **3.7.1 Disenrollment by Enrollees in Rural Counties**

Enrollees living in rural counties may disenroll from the Health Plan at any time and for any reason. The following limited disenrollment requirements apply only to Enrollees living in Davis, Salt Lake, Utah, and Weber counties.

### **3.7.2 Limited Disenrollment—Generally**

The Department requires Enrollees to be enrolled with the same Health Plan for up to 12 months.

### **3.7.3 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) No more than three months have passed since the month the Enrollee's Medicaid card had a Health Plan printed on it;
  - (3) During the open enrollment period as defined by the Department; or
  - (4) When the Enrollee has been automatically re-enrolled after being disenrolled solely because the Enrollee lost Medicaid eligibility for a period of two months or less and the temporary loss of Medicaid eligibility caused the Enrollee to miss the annual disenrollment period.

### **3.7.4 Limited Disenrollment—With Cause**

- (A) Enrollees may request to transfer from one Health Plan to another at any time for the following reasons:
- (1) The Enrollee moves out of the Health Plan's service area;
  - (2) The Enrollee needs related services to be performed at the same time and not all services are available within the network, and the Enrollee's 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) Health Plan does not, because of moral or religious objections cover the service the Enrollee seeks.
  - (5) Enrollee becomes emancipated or is added to a different Medicaid case; or
  - (6) If the Health Plan makes changes to its provider network that interferes with an

Enrollee's continuity of care with the Enrollee's provider of choice.

### **3.7.5 Process for Requesting Health Plan Change**

- (A) The Enrollee may change Health Plans by submitting an oral or written request to the Department. The enrollee must declare the Health Plan in which he or she wishes to enroll should the disenrollment be approved.
- (B) If the Enrollee makes a request for disenrollment directly to the Contractor the Contractor shall forward the request for disenrollment to the Department.
- (C) The Department shall review each disenrollment request from an Enrollee to determine if the request meets the criteria for cause, and if so, the Department shall allow the Enrollee to switch to another Health Plan. If 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 his or her 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, the Department issues a new Medicaid card and the disenrollment is indicated on the Eligibility transmission. The effective date of an approved disenrollment request shall be no later than the first day of the second month following the month in which the Enrollee filed the request.

### **3.7.6 Enrollees in an Inpatient Hospital Setting**

In the event that a new enrollee is a patient in an inpatient hospital setting on the date the new Enrollee's name appears on the Contractor Eligibility Transmission, the obligation of the Contractor to provide Covered Services to such person shall commence following discharge. If an enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as terminated for any reason other than eligibility on the Contractor Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the Contractor shall remain financially responsible for such care until discharge.

### **3.7.7 Study of Enrollees who Disenrolled**

As necessary, the Department and Contractor shall work cooperatively to conduct an analysis of Enrollees who have voluntarily disenrolled from the Contractor's Health Plan. The results of the analysis shall include explanations of patterns of disenrollments and strategies or a corrective action plan to address unusual rates or patterns of disenrollment. The Department shall inform the Contractor of such disenrollments. For disenrollments other than eligibility, the Department agrees to provide the Contractor with disenrollment data in a mutually agreed upon electronic format conducive to identifying enrollment patterns.

## **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 his or her special needs (except when his or her continued enrollment in the Health Plan seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees).

### **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 member 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 this Contract; or
- (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.

### **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 thirty 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 an Appeal**

If the Department approves the Contractor's disenrollment request, the Contractor shall give the Enrollee thirty days written notice of the proposed disenrollment, and shall notify the Enrollee of his or her opportunity to invoke the Contractor's Appeal Process. The Contractor shall give a copy of the written notice to the Department at the time the notice is sent to the Enrollee.

### **3.8.5 Refusal of Re-Enrollment**

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

### **3.8.6 Automatic Re-Enrollment**

An Enrollee who is disenrolled from the Health Plan solely because he or she loses Medicaid eligibility shall automatically be re-enrolled if the Enrollee has not been a Medicaid Eligible Individual for two months or less.

## **3.9 Enrollee Transition Between Health Plans**

### **3.9.1 Acceptance of Pre-Enrollment Prior Authorizations**

For Covered Services other than inpatient services, if authorization has been given for a Covered Service and a Medicaid Eligible Individual transitions between Health Plans prior to the delivery of such Covered Service, the receiving Health Plan shall be bound by the relinquishing Health Plan's prior authorization until the receiving Health plan has evaluated the medical necessity of the service and agrees with the relinquishing Health Plan's prior authorization or has made a different determination.

### **3.9.2 Provision of Medical Records to Enrollee's New Health Plan**

When Medicaid Eligible Individuals are transitioned between Health Plans the relinquishing Health Plan's Provider shall submit, upon request of the new Health Plan's provider, any critical medical information about the transitioning Medicaid Eligible Individual prior to the transition including, but not limited to, whether the Medicaid Eligible Individual is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, receiving dialysis or is chronically ill. Chronic Illness includes, but is not limited to, diabetes, hemophilia, or HIV.

## **3.10 Enrollee Transition from FFS to Health Plan for from Health Plan to FFS**

### **3.10.1 Contractor Acceptance of Pre-Enrollment Prior Authorization**

For Covered Services other than inpatient, home health services, and medical equipment if authorization has been given for a Covered Service and a Medicaid Eligible Individual transitions from Medicaid fee-for-service to enrollment with the Contractor's Health Plan prior to the delivery of such Covered Service, the Contractor shall be bound by the Department's fee-for-service prior authorization until the Contractor has evaluated the medical necessity of the service and agrees with the Department's fee-for-service prior authorization or has made a different determination.

### **3.10.2 Department Acceptance of Contractor's Prior Authorization**

For Covered Services other than inpatient services, if authorization has been given for a Covered Service and an Enrollee transitions to Medicaid fee-for-service prior to the delivery of such Covered Service, the Department shall be bound by the Contractor's prior authorization until the Department has evaluate the medical necessity of the service and agrees with the Contractor's fee-for-service prior authorization or has made a different determination.

### **3.10.3 Provision of Medical Records to Enrollee's Health Plan or the Department**

When Medicaid Eligible Individuals are transitioned from the Contractor's Health Plan to fee-for-service or from 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 Medicaid 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, 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.

## **ARTICLE 4: BENEFITS**

### **4.1 General Provisions**

#### **4.1.1 Basic Standards**

- (A) The Contractor shall provide to Enrollees under this Contract, directly or through arrangements with providers, all Medically Necessary Covered Services described in Attachment C as promptly and continuously as is consistent with generally accepted standards of medical practice.
- (B) The Contractor shall ensure that all Covered Services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid (set forth in 42 CFR 440.230).
- (C) The Contractor shall ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- (D) The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- (E) The Contractor may place appropriate limits on a service on the basis of criteria applied under a state plan such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

## **4.2 Scope of Services**

### **4.2.1 Scope of Covered Services**

Except as otherwise provided for cases of Emergency Services, the Contractor is responsible to arrange for all covered services listed in the Web-based look-up tool and the Departments' Provider Manuals.

The Contractor is responsible for payment of Emergency Services 24 hours a day, 7 days a week whether the services were provided by a network or out-of-network provider and whether the service was provided inside or outside of the Contractor's Service Area.

### **4.2.2 Changes to Benefits**

Amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines, or policies, insofar as they affect the scope or nature of benefits available to a Medicaid Eligible Individual shall be considered incorporated by this Contract and the Contractor shall be required to provide those benefits to Medicaid Eligible Individuals.

### **4.2.3 Court and Administrative Orders Regarding Benefits**

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

## **4.3 Covered Services—Emergency Services**

### **4.3.1 Emergency Services Generally**

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

(B) The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contractual relationship with the Contractor.

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

(D) The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within 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-plan physician or other qualified 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 unstablized 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 ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Enrollee.

(D) In the event an Enrollee presents to an Emergency Room with both a physical health and mental health diagnosis, and the Enrollee requires medical stabilization, the Contractor shall pay for the facility charge and any ancillary services the entire Emergency Room visit.

#### **4.3.3 Payment Liability in the Absence of a Clinical Emergency**

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

#### **4.3.4 Payment Liability for Referrals**

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

## **4.4 Covered Services—Post Stabilization Care**

### **4.4.1 Post Stabilization Care Generally**

(A) 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. However, in situations where a Provider demonstrates that the Enrollee received Emergency Services related to an Emergency Medical Condition during the inpatient admission, the Contractor shall reimburse the Provider in accordance with the payment provisions governing Emergency Services.

### **4.4.2 Pre-Approved Post-Stabilization Care Services**

The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's plan that are pre-approved by a Contractor representative.

### **4.4.3 Other Contractor-Liable Post-Stabilization Care Services**

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

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

- (1) The Contractor does not respond to a request for pre-approval within one hour of the request;
- (2) The Contractor cannot be contacted; or
- (3) The Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with the care of the Enrollee until a Contractor physician is reached, or one of the following criteria, found in 42 CFR 422.113(c)(3) is met:
  - (i) A Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
  - (ii) A Contractor physician resumes responsibility for the Enrollee's care;

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

(iv) The Enrollee is discharged.

#### **4.4.4 Limitation on Charges to Enrollees**

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

### **4.5 Covered Services -- Care Provided in Skilled Nursing Facilities and LTAC Hospitals**

#### **4.5.1 In General: Stays Lasting 30 Days or Less**

The Contractor shall provide care for Enrollees in skilled nursing facilities and Long Term Acute Care (LTAC) hospitals and then reimburse such facilities when the plan of care includes a prognosis of recovery and discharge within 30 days. It is the responsibility of a Contractor physician to make sure the determination if the patient shall require the service of a nursing facility or LTAC for more or less than 30 days.

#### **4.5.2 Process for Stays More than 30 Days**

(A) When the prognosis of an Enrollee indicates that care in a nursing or LTAC facility for more than 30 days will be required, the Contractor shall:

(1) Notify the Enrollee, hospital discharge planner, and nursing or LTAC facility that the Contractor shall not be responsible for the services provided for the Enrollee during the stay at the facility; and

(2) Notify the Department's Bureau of Managed Health Care ("BMHC") of this determination and the BMHC shall change the status of the Enrollee to fee-for-service.

#### **4.5.3 Process for Stays Initially 30 Days or Less Converted to Over 30 Days**

(A) When the prognosis of skilled nursing or LTAC facility services is anticipated to be 30 days or less, but during the 30 day period the Contractor determines that the Enrollee shall require skilled nursing or LTAC facility services for more than 30 days the Contractor shall:

(1) Notify the nursing or LTAC facility that a determination has been made that the Enrollee will require services for more than 30 days; and

(2) Notify the BMHC of the determination that the Enrollee will require services in a nursing or LTAC facility for more than 30 days; and

(3) The Contractor shall be responsible for payment for three working days after the Contractor has notified the nursing or LTAC facility that skilled nursing care will be required for more than 30 days.

#### **4.5.4 Failure to Disenroll**

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

### **4.6 Covered Services – Hospice**

#### **4.6.1 Hospice, Generally**

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

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

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

### **4.7 Covered Services—Inpatient Hospital Services for Scheduled Admissions**

#### **4.7.1 Financial Responsibility for Inpatient Hospital Services**

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

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

### **4.8.1 General Provisions**

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

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

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

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

When DHS personnel suspects physical and/or sexual abuse, the Contractor shall ensure that the child has access to an appropriate examination within 24 hours of notification that the child was removed from the home. If the Contractor cannot provide an appropriate examination, the Contractor shall ensure the child has access to a provider who can provide an appropriate examination within the 24 hour period.

### **4.8.3 Children in Custody, Initial Health Screening**

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

### **4.8.4 CHEC Exams**

The Contractor shall ensure that children in custody have access to a Child Health Evaluation and Care (“CHEC”) screening within 30 calendar days of notification that the child was removed

from the home. Whenever possible, the CHEC screening should be completed within the five day time-frame. Additionally the Contractor shall ensure that children in custody have access to a CHEC screening according to the CHEC periodicity schedule until age six, then annually thereafter.

## **4.9 Covered Services—Organ Transplantations**

### **4.9.1 Generally**

All organ transplantation services are the responsibility of the Contractor for all Enrollees in accordance with the criteria set forth in Utah Administrative Code R414-10A.

### **4.9.2 Specific Organ Transplantations Covered**

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

### **4.9.3 Psycho-Social Evaluation Required**

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

### **4.9.4 Out-of- State Transplantations**

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

## **4.10 Covered Services—Mental Health Services**

### **4.10.1 Mental Health Services, Generally**

(A) When an Enrollee presents with a possible mental health condition 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 conditions may be handled by the Primary Care Provider or referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. The Primary Care Provider may seek consultation from the Prepaid

Mental Health Plan when the Primary Care Provider chooses to manage the Enrollee's symptoms.

## **4.11 Excluded Services—Habilitative and Behavioral Management Services**

### **4.11.1 Generally**

Habilitative and behavioral management services are not the responsibility of the Contractor. If habilitative services are required, the Contract shall have a process to refer the Enrollee to the Division of Services for People with Disabilities ("DSPD"), the school system, the Early Intervention Program, or similar support agency. The Enrollee should also be referred to DSPD for consideration of other benefits and programs that may be available through DSPD.

Habilitative services are defined in Section 1915(C)(5)(a) of the Social Security Act as "services designed to assist individuals in requiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

## **4.12 Covered Services-- Out-Of-State Accessory Services**

### **4.12.1 Out-of-State Accessory Services, Generally**

The Contractor shall follow the Department's criteria for coverage of food, lodging, transportation, and airfare expenses as outlined in the Utah Medicaid Provider Manual for Medical Transportation.

## **4.13 Covered Services – Non-Contractor Prior Authorized Services**

### **4.13.1 Prior Authorizations, Generally**

The Contractor shall honor prior authorizations for organ transplantations and any other ongoing services 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.

### **4.13.2 Non-Contracted Authorized Services, Non-Participating Provider**

(A) Services for which the Contractor requires a prior authorization or prior notification from a provider and for which the Department issued an authorization for payment in error, the Contractor shall pay the Provider of the service at the Medicaid rate, if all of the following conditions are met:

- (1) The servicing provider is not a participating provider under contract with the Contractor;
- (2) The Department issued a prior authorization for an Enrollee to the servicing provider;
- (3) The Provider filed an Appeal with the Contractor within the required time frame for filing an Appeal;

(4) The servicing provider has completed the Contractor's appeals process without resolution of the claim, and has requested a hearing with the State Formal Hearings Unit requesting payment for the services rendered; and

(5) The Hearing Officer determines that the service rendered was a Medically Necessary service covered under this Contract.

## **4.14 Covered Services—Additional Services for Enrollees with Special Health Care Needs**

### **4.14.1 Identification of Enrollees with Special Needs**

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.

### **4.14.2 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 have 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.

### **4.14.3 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. The process for requesting specialist care shall be clearly described by the Contractor in the Contractor's Member Handbook, and explained to each Enrollee during the initial contact with the Enrollee.

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

#### **4.14.4 Survey of Enrollees with Special Health Care Needs**

At least every two years, the Contractor in conjunction with the Department shall survey a sample of Enrollees With Special Health Care Needs using a national consumer assessment questionnaire to evaluate their perceptions of services they have received. The Department shall analyze the results of the surveys, and shall take corrective action as necessary.

#### **4.14.5 Collaboration with Other Programs**

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

(B) The Contractor shall 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.

#### **4.14.6 Case Management and Coordination of Care Program**

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

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

(C) A case management program includes, but is not limited to:

- (1) Methodologies to determine the frequency and duration of Case Management services through application of the Health Plan's criteria;

- (2) Mechanisms to refer to and coordinate with other state agencies and community resources as necessary;
- (3) Assisting with and the monitoring of Enrollees' follow-up and specialty care to ensure compliance with treatment plans and ensure that Enrollees receive recommended follow up and specialty care.
- (4) Coordination with the Contractor's disease management program.
- (5) Referral of enrollees to Medical Homes, where appropriate.
- (6) Protocols to address Enrollees who are non-compliant.

## **4.15 Pharmacy Benefits**

### **4.15.1 Pharmacy, Generally**

- (A) The Contractor shall cover prescription drugs as a Covered Service as stated under this Contract and in compliance with Federal and State Laws.
- (B) All covered drugs or related products must have a valid NDC number.
- (C) The Contractor shall ensure that its Providers are writing prescriptions on a tamper-resistant prescription pad in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recover, and Iraq Accountability Appropriations Act of 2007.
- (D) The Contractor shall designate a pharmacy benefit manager responsible for processing pharmacy claims, sending the adjudication report, and who shall act as the Contractor's technical liaison with the Department for pharmacy-related issues.

### **4.15.2 Covered Drugs, PDL-Plus File**

- (A) The Department shall electronically provide to the Contractor a data feed which shall be designated the PDL-Plus file. The PDL-Plus file shall be provided to the Contractor on a weekly<sup>1</sup> basis.
- (B) The PDL-Plus file shall contain:
  - (1) A list of all prescribed drugs that the Contractor is responsible for covering;
  - (2) A list of drugs which are carved out of the Contractor's coverage responsibility but will still be covered by the Department;

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<sup>1</sup> DRAFT CONTRACT NOTE: The Department currently intends for this file to be sent on a weekly basis. This timeframe may be more or less frequent depending on the needs of the Department and the Contractors.

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

(4) DME which the Contractor is responsible for covering as a pharmacy benefit; and

(5) A list of over-the-counter drugs that the Contractor is responsible for covering.

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

(D) The Contractor shall cover all of the prescription drugs on the Department's PDL-Plus file that are not specifically carved out as being the Department's responsibility.

#### **4.15.3 Rebateable Drugs**

(A) The PDL-Plus file shall include an indicator for the drugs which are eligible for a rebate under the Medicaid Drug Rebate Program enacted by the Omnibus Budget Reconciliation Act of 1990.

(B) The Contractor's Policies and Procedures shall require that Contractor's providers prescribe the drugs that are eligible for a rebate under the Medicaid Drug Rebate Program. The Contractor shall submit a quarterly report of non-rebateable drug use.

(C) The Contractor's may only cover compound component parts that are eligible for a rebate pursuant to the Medicaid Drug Rebate Program.

(D)<sup>2</sup>

#### **4.15.4 Physician Enrollment with Medicaid**

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

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

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<sup>2</sup> DRAFT CONTRACT NOTE: The Department intends to add in additional information regarding how rebates will be apportioned between the Department and the Contractor, and how the rebates will be reflected in the rates. The Department also intends to add in language regarding 340(B) Community Health Centers. The Department is currently doing research on these pharmacy issues and will provide contract language as it is developed.

(C) All claims for prescription drugs which do not contain an appropriate Utah Medicaid Provider ID may not be paid by the Contractor.

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

(E) The Contractor is responsible for ensuring that its Providers are familiar with the Contractor's Preferred Drug List and is aware of what drugs are Covered Services.

#### **4.15.5 Preferred Drug List**

(A) The Contractor shall develop policies and procedures to govern prescription drug prior authorizations.

(B) The Contractor may use the Department's Preferred Drug List or may create its own Preferred Drug list. A Preferred Drug List is a list of drugs that are deemed to cost-effective and which do not require a prior authorization.

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

(1) On a yearly basis, the Contractor's Preferred Drug list and the methodology used by the Contractor to set its Preferred Drug List shall be subject to review and approval by the Department's DUR board. Additionally, the DUR board at its discretion, may request and review contractor's PDL list and an explanation of the methodology used by the Contractor in making its prescription drug list.

(i) The Contractor shall provide any documents requested by DUR within 15 days of the DUR's request.

(ii) The Department's DUR board may override the Contractor's Preferred Drug List if the DUR Board determines that the Contractor's Preferred Drug List violates this Contract, violates applicable State and Federal Laws or appears to create an adverse selection process.

#### **4.15.6 Enrollees Eligible for Medicare Part D**

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

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

#### **4.15.7 Post-Adjudication File**

(A) The Contractor shall send a post-adjudication history file to the Department. The Post-Adjudication file shall be in a format requested by the Department and shall be based on an NCPDP format. The Contractor's first post-adjudication file shall be submitted to the Department on January 2, 2012. Thereafter, the file shall be submitted every Wednesday.<sup>3</sup>

(B) Contractor must ensure that its post-adjudication report is accurate.

(C) The Contractor shall correct any errors found in the Post-Adjudication file within 20 days of the discovery of the error by the Contractor or Department. If the Contractor fails to correct the errors found in the Post-Adjudication file, the Department may impose sanctions as described in Article 15 of the Contract

(D) In the event that the Contractor chooses to cover prescription drugs that are not found on the Department's PDL-Plus file or drugs that are non-rebateable, then the Contractor shall not report those prescribed drugs in the Department's Post Adjudication File.

(E) If the Contractor pays for a prescription that is adjudicated more than twelve (12) months from the date of service, the NCPDP post adjudication record will be rejected for failure to process in accordance with 42 CFR 447.45.

#### **4.15.8 Federal DUR Reporting**

(A) The Contractor shall assist the Department in collecting any data that the Department needs to complete the Federal DUR Report.

(B) The Contractor shall provide the Department with any information requested by the Department to complete the Federal DUR report within 30 days of the Department's request.

### **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 Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Contract. In establishing and maintaining the network of Providers the Contractor must consider the following:

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<sup>3</sup> DRAFT CONTRACT NOTE: This is the Department's current expectation, this due date and the frequency of the post-adjudication report may be subject to change depending on the needs and technical capabilities of the Department and the Contractor.

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

### **5.1.2 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.

### **5.1.3 Second Opinions**

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

### **5.1.4 Out of Network Services**

(A) If the network is unable to provide Medically Necessary Covered Services under this Contract to a particular Enrollee, the Contractor shall adequately and timely cover these services out of network for the Enrollee for as long as the Contractor is unable to provide them.

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

### **5.1.5 Timely Access**

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

### **5.1.6 Timely Access Monitoring**

The contractor shall establish mechanisms to ensure compliance by network Providers and shall monitor its Providers regularly to determine compliance by Providers. If there is failure to comply, the Contractor shall take corrective action.

## **5.2 Relationships with Subcontractors and Delegation of Duties**

### **5.2.1 Generally**

- (A) The Contractor shall ensure that all of its Subcontracts are in writing.
- (B) The written agreements with the Subcontractor shall include any general requirements of this Contract that are appropriate to the service or activity being delegated under the Subcontract, including confidentiality requirements and shall assure that all duties of the Contractor under this Contract are performed.
- (C) Prior to entering into a Subcontract, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- (D) The Contractor shall oversee and be held accountable for any functions and responsibilities that it delegates to any subcontractor.
- (E) The Contractor shall monitor the subcontractor's performance on an on-going basis that shall be subject to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations.
- (F) If the Contractor identifies in its Subcontractor deficiencies or areas of improvement, the Contractor and the Subcontractor shall take corrective action.
- (G) No subcontract shall terminate or limit the legal responsibility of the Contractor to the Department to assure that all activities under this contract are carried out. The Contractor is not relieved of its contractual responsibilities to the Department by delegating those responsibilities to a subcontractor.
- (H) Within 15 days of receiving a request from the Department, the Contractor shall make all Subcontracts available to the Department.

### **5.2.2 Written Agreements, Specific Requirements**

- (A) Each of the Contractor's Subcontracts shall contain the following:
  - (1) A specific description of the activities, service or responsibility being delegated to the Subcontractor.
  - (2) A provision outlining Contractor's ability to revoke delegation or impose other

sanctions if the subcontractor's performance is inadequate.

(3) A provision stating that if the subcontractor becomes insolvent or bankrupt Enrollees shall not be liable for the debt of the subcontractor.

(4) A provision stating that the subcontractor, acting within the lawful scope of his or her practice, shall not be prohibited from advising or advocating on behalf of an Enrollee who is his or her patient for the following:

- (i) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- (ii) Any information the Enrollee needs in order to decide among all relevant treatment options;
- (iii) The risks, benefits, and consequences of treatment or non-treatment; and
- (iv) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(5) Adequate information about the Grievance, Appeal, and State fair hearing procedures and timelines so that the Provider can comply with the Grievance Systems requirements including:

- (i) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;
- (ii) The Enrollee's right to file Grievances and Appeals;
- (iii) The requirements and timeframes for filing a Grievance or Appeal;
- (iv) The availability of assistance in the filing process;
- (v) The toll-free numbers that the Enrollee can use to file a Grievance or Appeal by phone;
- (vi) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or request a State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and
- (vii) Any State-determined provider Appeal rights to challenge the failure of the Contractor to cover a service.

### **5.2.3 Other Provider-Subcontractor Requirements**

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

(B) The Contractor shall ensure that 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 providers shall be aware of the Contractor's Quality Assurance Plan and activities. All of the Contractor's agreements with Providers shall include a requirement securing cooperation with the Contractor's Quality Assurance Plan and activities and shall allow the Contractor access to the medical records of Enrollees being treated by Contractor's Providers.

(D) All physicians who provide services 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 Providers are either a fee-for-service provider or are enrolled with the Department as a "limited enrollment provider." The Contractor shall include a provision in its Provider agreements that the Provider shall either be a fee-for-service provider or enrolled as a "limited enrollment provider."

## **5.3 Contractor's Selection of Providers**

### **5.3.1 Provider Enrollment with Medicaid**

All Providers to whom the Contractor makes payment must be enrolled with the Department as a full or limited Medicaid Provider.

### **5.3.2 Provider Selection, Generally**

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

### **5.3.3 Excluded Providers**

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

### **5.3.4 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 providers and re-credentialing Providers who have signed contracts or agreements. The Contractor's written policies and procedures shall follow the Department's policies that require:

- (1) Provider completion of Contractor written applications;
- (2) Procedures for assuring that potential and current 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.

### **5.3.5 Timeframe for Re-Credentialing**

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

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

### **5.3.6 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.

### **5.3.7 Documentation**

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

### **5.3.8 Non-Inclusion of Providers**

(A) The Contractor shall report to the Department 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.

### **5.3.9 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.

### **5.3.10 Federally Qualified Health Centers**

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

## **5.4 Payment of Provider Claims**

### **5.4.1 General Requirements**

(A) The Contractor shall pay its 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 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, as well as the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR 438.6(a)(12) and 447.26.

(B) The Contractor shall require that its Providers identify Provider Preventable Conditions in a form or frequency as specified by the Department.

## **Article 6: Program Integrity Requirements**

### **6.1 Fraud, Waste and Abuse**

#### **6.1.1 Generally**

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

(B) The Contractor's compliance plan shall be designed to identify and refer suspected Fraud, Waste, and Abuse activities.

(C) The Contractor shall cooperate with the Department, the Utah OIG, and the Medicaid Fraud Control Unit (“MFCU”) in any Waste, Fraud, and Abuse investigations.

### **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 standards;
- (2) The designation of a compliance officer and a compliance committee that are accountable to senior management;
- (3) Effective training and education for the compliance officer and the Contractor’s employees;
- (4) Effective lines of communication between the compliance officer and the Contractor’s employees;
- (5) Enforcement of standards through well-publicized disciplinary guidelines;
- (6) Provisions for internal monitoring and auditing including:
  - (i) Mechanism(s) for verifying with Enrollees that Covered Services provided or reimbursed by the Contractor were actually furnished to Enrollees (such as periodic questionnaires, telephone calls, etc., to a sample of Enrollees); and
  - (ii) Documentation of the sampling methodology and the schedule for conducting the verifications; and
- (7) Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract.

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

(A) Pursuant to Utah Code Ann. §63J-4a-101 *et seq.*, if the Contractor or a Provider becomes aware of potential Provider-related Fraud, Waste, or Abuse, the Contractor or the Provider shall report the incident, in writing, to the Utah Office of Inspector General of Medicaid Services (“Utah OIG”) or MFCU in the Utah Attorney General’s Office.

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

(C) Reports of Fraud, Waste, or Abuse made by the Contractor or a Provider shall be made to the Utah OIG or MFCU and the Department within 15 calendar days of detection of the incident

of provider-related Fraud, Waste, or Abuse.

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

- (1) Name and identification number of the suspected individual;
- (2) Source of the complaint (if anonymous, indicate as such);
- (3) Type of provider or type of staff position, if applicable;
- (4) Nature of complaint; and
- (5) Approximate dollars involved, if applicable.

#### **6.1.4 Reporting Recipient-Related Fraud, Waste, and Abuse**

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

### **6.2 False Claims Act**

#### **6.2.1 False Claims Act, Generally**

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

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

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

#### **6.2.2 Information Required in False Claims Act Policies**

(A) The written policies shall provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31,

United States Code, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs.

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

### **6.2.3 Dissemination of False Claims Act Policies and Procedures**

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

(B) The Contractor shall require that its providers disseminate the written policies and procedures to its employees and agents.

(C) The Contractor shall have written policies and procedures to monitor that its Providers are disseminating the Contractor's False Claims Act policies and procedures to the Providers' employees and agents.

### **6.2.4 Employee Handbook**

(A) If the Contractor has an employee handbook, the Contractor shall include the following information:

(1) A specific discussion of the False Claims Act established under sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs;

(2) The rights of employees to be protected as whistleblowers; and

(3) The Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

## **6.3 Prohibited Affiliations with Individuals Debarred by Federal Agencies**

### **6.3.1 General Requirements**

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

(1) The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the Contractor's equity who is disbarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under

regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order.

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

(3) The Contractor shall not knowingly have a relationship with 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.

(i) Per the Federal Acquisition Regulation, "business concerns are affiliates of each other, if directly or indirectly, either one controls or has the power to control the other, or another concern controls or has the power to control both. In determining whether affiliation exists, consideration is given to all appropriate factors including common ownership, common management, and contractual relationships; *provided* that restraints imposed by a franchise agreement are not considered in determining whether the franchisor controls or has the power to control the franchisee, if the franchisee has the right to profit from its effort, commensurate with ownership, and bears the risk of loss or failure. Any business entity may be found to be an affiliate whether or not it is organized for profit or located in the United States."

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

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

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

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

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

(D) If the individuals listed in 6.3.2(B)(1), (2), and (3) are not found in the database searches, the Contractor is required to determine if the Individual is 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. Affiliate is defined in Section 6.3.1(A)(3)(i) of this Contract.

(1) The Contractor shall provide the Department's Prohibited Affiliation Attestation Form to the individuals listed in 6.3.2(B)(1), (2) and (3). 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 6.3.2(B)(1)(2), and (3) that exist on the effective date of this Contract amendment, 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 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

ensure that those individuals have not been added to the databases. The party conducting the search shall keep records showing that these monthly searches were conducted.

### **6.3.3 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 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 Section 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.

### **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 6.3.1(A)(1), (2), or (3) of this Contract, the Contractor must immediately, and no later than 30 days, notify the Department. Notification to the Department shall be by email and shall include the name, Social Security Number, and type of relationship the person has with the Contractor.

(B) If the Contractor obtains an Attestation from an individual stating that the individual has an affiliate who has been disbarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under any guidelines implementing such order, the Contractor shall provide an electronic copy of the attestation form to the Department no later than 30 calendar days from the date of the individual providing the attestation to the Contractor.

(B) 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 ensure that the Providers are not restricted Providers.

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

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

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

(E) Once the Contractor has credentialed the potential provider and enters into a Provider agreement, 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 Provider, the Contractor shall include this requirement in its written Provider agreement. The Contractor shall require the provider to have policies and procedures for conducting the delegated searches, for maintaining documentation that such searches were conducted, and for reporting any Exclusion findings to the Contractor within 30 calendar days of the discovery.

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

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

### **6.4.3 Excluded Provider Payment Prohibition**

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

## **6.5 Disclosure of Ownership and Control Information**

### **6.5.1 Disclosure Information**

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

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

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

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

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

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

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

(3) Managing Employees shall disclose:

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

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

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

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

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

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

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

(6) In the event that the Contractor subcontracts with an entity to perform administrative functions, the Contractor shall require Managing Employees of the Subcontractor to disclose the following information:

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

### **6.5.2 Reporting Timeframes**

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

- (1) Upon the Contractor submitting a proposal in accordance with State's procurement process.
- (2) Upon the Contractor executing the Contract with the Department.
- (3) Upon renewal or extension of the Contract.
- (4) Within 35 calendar days after any change in Persons with Ownership or Control Interest.
- (5) Within 35 calendar days after any change in Managing Employees.

### **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 this Section 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.
- (6) If required to conduct Enrollee surveys, the survey results.

#### **6.6.4 Substantial Financial Risk**

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

#### **6.6.5 Information to Enrollees**

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

## **Article 7: Authorization of Services, Notices of Action, Medical Necessity Denials**

### **7.1 Service Authorization and Notice of Action**

#### **7.1.1 Policies and Procedures for Service Authorization Requests**

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

(B) The Contractor shall implement mechanisms to ensure consistent application of review criteria for service authorization decisions and consult with the requesting provider when

appropriate.

(C) The Contractor ensure that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

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

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

### **7.1.2 Time Frames and Procedures for Standard Service Authorizations**

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

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

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

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

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

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

(ii) Inform the Enrollee of his or her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

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

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

(A) If the Contractor denies a Service Authorization Request, or authorizes a requested service in an amount, duration or scope that is less than requested, the Contractor shall

make the decision and give a Notice of Action to the Enrollee as expeditiously as the Enrollee's health condition requires it, but no later than 14 calendar days from receipt of the request for Service Authorization. The Contractor shall also notify the requesting Provider, although the notice need not be in writing.

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

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

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

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

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

(ii) Inform the Enrollee of his or her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision; and

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

#### **7.1.4 Time Frames and Procedures for Expedited Service Authorization Decisions**

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

(1) Make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than three working days after the receipt of the request for Service Authorization;

(i) The Contractor may extend the three working day time period by up to 14 calendar days if:

(a) the Enrollee requests the extension; or

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

(B) If the Contractor denies an Expedited Service Authorization Request, or authorizes a requested service in an amount, duration or scope that is less than requested, the contractor shall follow the notification requirements found in 7.7.3.

### **7.1.5 Service Authorization Decisions Not Reached Within Required Time Frames**

In the event that the Contractor fails to make a service authorization decision within the proscribed time frames, such failure shall constitute a denial of services and shall be considered an adverse Action. The Contractor is required send out a Notice of Action to the Enrollee 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 and the Enrollee informs the Contractor that he or she disagrees with the changes in his or her treatment, this constitutes an Action. The Contractor shall notify the requesting provider and mail a Notice of Action to the Enrollee as expeditiously as the Enrollee's health condition requires and within the following time frames:

- (1) At least 10 days prior to the date of the Action; or
- (2) 5 days before the date of the Action if the Contractor has facts indicating that the Action should be taken because of probable Fraud by the Enrollee, and the facts have been verified, if possible, through secondary sources; or
- (3) by the date of the Action if:
  - (i) the Contractor has factual information confirming the death of the Enrollee;
  - (ii) the contractor receives a clear, written statement from the Enrollee that:
    - (a) the Enrollee no longer wants the services; or
    - (b) the Enrollee gives information that requires termination or reduction of services and indicates that he or she understands that this shall be the result of supplying that information;
- (4) the Enrollee has been admitted to an institution where he is ineligible for further services;
- (5) the Enrollee's whereabouts are unknown and the post office returns mail directed to him indicating no forwarding address. In this case any discontinued services shall be reinstated if his whereabouts become known during the time he is eligible for services;
- (6) the Enrollee has been accepted for Medicaid services by another local jurisdiction; or
- (7) the Enrollee's physician prescribes the change in the level of medical care.

## **7.2 Other Actions Requiring Notice of Action**

### **7.2.1 Action to Deny Payment in Whole or Part for a Service**

(A) The Contractor shall notify the requesting provider of decisions to deny payment in whole or in part.

(B) The Contractor shall also mail the Enrollee a written Notice of Action at the time of the Action affecting a claim. A Notice of Action to the Enrollee is not necessary under the following circumstances:

- (1) the Provider billed the Contractor in error for a non-authorized service;
- (2) the claim included a technical error (incorrect data including procedure code, diagnosis code, Enrollee name or Medicaid identification number, date of service, etc.);  
or
- (3) the Enrollee became eligible after the first of the month, but received a service during that month before becoming Medicaid eligible.

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

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

### **7.2.3 Action Due to Failure to Resolve Appeals or Grievances Within Proscribed Timeframes**

(A) Failure of the contractor to act within the proscribed timeframes provided for resolving and giving resolution notice for Appeals or Grievances constitutes an Action. The Contractor shall provide a Notice of Action to the Enrollee at the time the Contractor determines the time frame for resolving the Appeal or Grievance will not be met.

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

(C) When issuing a Notice of Action due to failure to resolve an Appeal within the required timeframe, the Contractor shall include in the Notice of Action information regarding the procedures and timeframes for filing a request for a State Fair Hearing rather than information on filing an Appeal. The Contractor shall also attach to the Notice of Action a copy of the request

form for a Medicaid State Fair Hearing that the Enrollee can submit to request a State Fair Hearing.

## **7.3 Required Content of Notice of Action**

### **7.3.1 Generally**

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

(B) All written Notices of Action required by this Contract shall explain the following:

- (1) The Action the Contractor has taken or intends to take;
- (2) The reason for the Action;
- (3) The date the Action will become effective when the Action is to terminate, suspend, or reduce a previously authorized Covered Service;
- (4) The Enrollee's or Provider's right to file an Appeal of the Action with the Contractor;
- (5) The procedures for filing an Appeal;
- (6) The circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution;
- (7) The Enrollee's right to have disputed services continue pending resolution of the Appeal of an Action to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider
- (8) How to request that the disputed services be continued, and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is adverse to the Enrollee, to the extent that they were furnished solely because of this Contract requirement in accordance with 42 CFR 438.420; 438.404(b)(7), and 431.230(b);
- (9) The following timeframe for filing an Appeal, as applicable:
  - (i) If the Enrollee is not requesting continuation of disputed services pending resolution of an Appeal of an Action to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider, and the original period covered by the original authorization has not expired, the Enrollee or the Provider, shall file the Appeal within 30 days from the date on the Contractor's Notice of Action; or
  - (ii) If the Enrollee is requesting continuation of disputed services pending

resolution of an Appeal of an Action to terminate, suspend or reduce a previously authorized course of treatment that was ordered by an authorized provider, and the original period covered by the original authorization has not expired, the Enrollee or Provider shall file the Appeal on or before the later of the following:

- (a) within 10 days of the Contractor mailing the Notice of Action; or
- (b) by the intended effective date of the Contractor's proposed action.

### **7.3.2 Attachment to Notice of Action –Written Appeal Request Form**

(A) The Contractor shall develop and include as an attachment to the notice of Action an Appeal Request form that 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) Provide a prompt (through the use of check boxes or other means) for Enrollees to:
  - (i) request expedited Appeal resolution if they chose to submit a written request for an expedited Appeal resolution; and
  - (ii) request continuation of disputed services, if applicable
- (2) Provide a statement that if continuation of disputed services is requested when a previously authorized service is terminated, suspended or reduced, that the Enrollee agrees that the Contractor may recover from the Enrollee the cost of the services furnished while the Appeal is pending if the Appeal decision is adverse to the Enrollee, to the extent that the services were furnished solely because of the requirements of this Contract that are based on federal regulation in 42 CFR 438.420.
- (3) Summarize the assistance available to the Enrollee may request to complete the Appeal Request form and how to request the assistance.
- (4) Include a reminder that if the Enrollee is not requesting an expedited Appeal resolution and the Enrollee files an Appeal orally, that the oral Appeal shall be followed by a written Appeal request within five working days from the date of the oral filing.

(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 State Fair Hearing.

## **7.4 Medical Necessity Denials**

### **7.4.1 Medical Necessity Denials, General Requirements**

(A) When the Contractor determines that a service shall not be covered because the services were not medically necessary, the Contractor shall send all documentation supporting its decision to the Department for review if:

- (1) there are no established national standards for determining medical necessity; and
- (2) the Department does not have medical necessity criteria for the service.

(B) The Contractor's determination to deny coverage shall not be final until the Department has had the opportunity to review the documentation. The Contractor shall send the required documentation to the Department as expeditiously as the Enrollee's health condition requires, but no later than 15 days after making its determination.

(C) The Department shall review the documentation and determine what the Department's decision would be regarding coverage of the service. The Department shall determine whether the service was medically necessary. If the Contractor disagrees with the Department's determination, the Contractor may then file a request for a 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 System for Enrollees that includes (1) a Grievance Process whereby an Enrollee, or provider acting on behalf of an Enrollee, may communicate a Grievance, (2) an appeals process whereby an Enrollee, or provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal of an Action, and (3) procedures for an Enrollee, or a Provider acting on behalf of an Enrollee, 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.

### **8.2 Appeal Requirements**

#### **8.2.1 Special Requirements for Appeals**

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

- (1) Provide that oral inquiries seeking to appeal an Action are treated as an Appeal, to

establish the earliest possible filing date for the Appeal;

(2) Ensure that the Enrollee or Provider understands that the oral Appeal shall be confirmed in writing, no later than five working days from the date of the oral filing, unless the Enrollee or the Provider requests an expedited resolution to the Appeal. These requests do not require a follow-up written request;

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

(4) Provide the Enrollee and his or her authorized representative the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records and any other documents and records considered during the appeals process; and

(5) Include as parties to the Appeal:

(i) the Enrollee and his or her representative, or

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

## **8.3 Standard Appeals Process**

### **8.3.1 Authority to File**

(A) An Enrollee or the Enrollee's legally authorized representative may file an Appeal; or

(B) A provider may file an Appeal.

### **8.3.2 Timing**

(A) The Enrollee or provider may file an Appeal of an Action within 30 calendar days from the date on the Contractor's Written Notice of Action; or

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

(1) within 10 days of the Contractor mailing the Notice of Action; or

(2) the intended effective date of the Contractor's proposed Action.

### 8.3.3 Procedures

- (A) The Enrollee or the provider may file an Appeal either orally or in writing.
- (B) Unless the Enrollee or a provider requests an expedited resolution of the Appeal (which does not require a written follow-up request), the oral Appeal shall be followed with a written, signed Appeal. The written, signed Appeal must be received within five working days from the date of the oral Appeal.
- (C) A provider may file the written, signed Appeal on behalf of the Enrollee and shall include the Enrollee's signed written consent.
- (D) If an Enrollee or provider requests an Appeal orally, the Contractor shall inform the Enrollee or provider that the oral filing of an Appeal must be followed with a written, signed appeal within five working days from the date of the oral Appeal.
- (E) The Contractor shall give Enrollees any reasonable assistance in completing required forms for submitting a written Appeal or taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.
- (F) The Contractor shall acknowledge receipt of the Appeal either orally or in writing and explain to the Enrollee the process that must be followed to resolve the Appeal.
- (G) The Contractor shall provide the Enrollee reasonable opportunity to present evidence, allegations of facts or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this in the case of an expedited Appeal resolution.
- (H) The Contractors shall provide the Enrollee and the Enrollee's authorized representative the opportunity, before and during the appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- (I) 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.
- (J) The Contractor shall ensure that the individuals who make the decision on an Appeal are individuals who:
  - (1) were not involved in any previous level of review or decision-making; and
  - (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the Department, in treating the Enrollee's condition or disease:
    - (i) an Appeal of a denial that is based on lack of medical necessity or

(ii) an Appeal that involves clinical issues.

### **8.3.4 Time Frames for Appeal Resolution and Notification**

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

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

(1) the Enrollee 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 Enrollee's interest.

(C) If the Contractor extends the time frame, and the extension was not requested by the Enrollee, the Contractor shall give the Enrollee written notice of the reason for the delay.

### **8.3.5 Format and Content of Notice of Appeal Resolution**

(A) The Contractor shall provide written Notice of Appeal Resolution to the affected parties. The written Notice of Appeal Resolution shall include the following:

(1) the results of the Appeal resolution process and the date it was completed; and

(2) for Appeals not resolved wholly in favor of the Enrollee, the Contractor shall include the following in the written Notice of Appeal Resolution:

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

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

(3) how to request continuation of disputed services;

(4) a statement that the Enrollee may be liable for the cost of disputed services provided if the State Fair Hearing decision upholds the Contractor's Action;

(5) the time frame for requesting a State fair hearing when continuation of disputed services is not requested and when continuation of disputed services is requested; and

(6) as applicable, a copy of either:

- (i) the standard request form for a Medicaid State Fair Hearing; or
- (ii) the request form for an expedited State Fair Hearing that the Enrollee must complete and submit to the Department to request a State Fair Hearing and continuation of disputed services;
- (iii) the standard request form for an expedited State Fair Hearing if the Enrollee has an expedited Appeal.

## **8.4 Process for Expedited Resolution of Appeals**

### **8.4.1 General Requirements**

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

- (1) The Contractor determines, based either upon a request from an Enrollee or in the Contractor's own judgment, that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function; or
- (2) A provider indicates that the standard timeframe for Appeal could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function.

### **8.4.2 Authority to File**

The Enrollee or a provider may file an expedited Appeal request either orally or in writing. Oral requests for expedited Appeal do not require a follow-up written request.

### **8.4.3 Timing**

(A) The Enrollee or provider may file an Appeal of an Action within 30 days from the date on the Contractor's Notice of Action;

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

- (1) within 10 days of the Notice of Action; or
- (2) the intended effective date of the Contractor's proposed Action.

#### **8.4.4 Procedures for an Expedited Appeal**

- (A) When an Enrollee or provider requests an expedited resolution of an Appeal, the Contractor shall inform the Enrollee or provider of the limited time available for the Enrollee to present evidence and allegations of fact or law in person and in writing.
- (B) The Contractor shall ensure that punitive action is not taken against a provider who either requests an expedited resolution to an Appeal or supports an Enrollee's Appeal.
- (C) The Contractor shall give Enrollees any reasonable assistance in making an expedited appeal. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- (D) The Contractor shall acknowledge receipt of the request for expedited Appeal resolution either orally or in writing and explain to the Enrollee 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.

#### **8.4.5 Denial of a Request for Expedited Appeal Resolution**

- (A) If the Contractor denies a request for an expedited resolution of an Appeal, the Contractor shall:
- (1) Adjudicate the Appeal using the standard time frame of no longer than 30 calendar days from the day the Contractor receives the Appeal, with a possible 14 calendar day extension for resolving the Appeal and Providing Notice of Appeal resolution to affected parties.
  - (2) Make reasonable effort to give the Enrollee prompt oral notice of the denial.
  - (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 Enrollee may file a Grievance regarding the denial of expedited resolution of an Appeal.

#### **8.4.6 Time Frame for Expedited Appeal Resolution and Notification**

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

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

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

(C) If the Contractor extends the timeframe and the extension was not requested by the Enrollee the Contractor shall give the Enrollee written notice of the reason for the delay.

#### **8.4.7 Format and Content of Expedited Appeal Resolution Notice**

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

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

#### **8.4.8 Continuation of Disputed Services During the Expedited Appeals Process**

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

- (1) the Action being appealed is to terminate, suspend or reduce a previously authorized course of treatment;
- (2) the services were ordered by an authorized provider;
- (3) the original period covered by the original authorization has not expired;
- (4) the Enrollee or provider files the Appeal timely, which means filing the Appeal on or before the later of the following:
  - (i) within 10 days of the Contractor mailing the Notice of Action; or
  - (ii) by the intended effective date of the Contractor's proposed Action; and
- (5) the Enrollee requests continuation of disputed services in the Appeal request.

#### **8.4.9 Duration of Continued Disputed Services and Enrollee Responsibility**

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

- (1) the Enrollee 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 Enrollee 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 Enrollee; or
- (4) the time period of service limits of a previously authorized service has been met.

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

#### **8.4.10 Reversed Appeal Resolutions**

(A) If the Contractor or State Fair Hearing officer reverses an action to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires.

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

### **8.5 State Fair Hearings**

#### **8.5.1 General Procedures**

(A) When the Enrollee or a provider 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 Enrollees and providers that the final decision of the Contractor may be appealed to the Department and shall give to the Enrollee and provider 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 Enrollee (or the Enrollee's legal guardian or representative), consistent with Utah Administrative Code R410-14-1, *et seq.*, to request a State Fair Hearing within 30 days from the date of the Contractor's Notice of Appeal Resolution.

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

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

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

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

(1) bring witnesses;

(2) establish all pertinent facts and circumstances;

(3) present an argument without undue interference; and

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

(F) The State Fair Hearing with the Department is a de novo hearing. If the Enrollee or provider 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 Enrollee shall be notified in writing of the State fair hearing decision and any appeal rights as provided by State and Federal law.

## **8.6 Grievances**

### **8.6.1 Authority to File a Grievance**

(A) An Enrollee may file a Grievance; or

(B) A provider may file a grievance.

### **8.6.2 Procedures**

(A) The Enrollee or the provider may file a Grievance orally or in writing.

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

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

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

(1) were not involved in any previous level of review of decision-making involving the Grievance; and

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

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

(ii) a Grievance that involves clinical issues.

### **8.6.3 Timeframes for Grievance Disposition and Notification**

(A) The Contractor shall dispose of each Grievance and provide notice to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 45 calendar days from the day the Contractor receives the Grievance.

(B) For written Grievances, the Contractor shall notify the affected parties in writing of the disposition of the Grievance. For Grievances received orally, the Contractor shall notify the affected parties of the disposition either orally or in writing.

(C) If the Enrollee or a provider files a Grievance with the Department, the Department shall apprise the Enrollee or the provider, of his or her right to file the Grievance with the Contractor and how to do so.

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

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

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

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

(1) the Enrollee requests the extension; or

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

(E) If the Contractor extends the time frame, and the extension was not requested by the Enrollee, the Contractor shall give the Enrollee written notice of the reason for the delay.

## **8.7 Dispute Resolution, Reporting and Documentation**

### **8.7.1 Reporting Requirements**

(A) The Contractor shall maintain complete records of all Appeals and grievances and submit semi-annual reports summarizing Appeals and Grievances using Department specified reporting templates. 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 maintain all documentation relating to Appeals which includes, but is not limited to the following:

(1) written Notices of Action;

(2) a log of all oral Appeals and oral requests for expedited resolution of Appeals including:

(i) date of the oral requests;

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

(iii) date of denials of requests for expedited Appeals resolution; and

(3) copies of written standard Appeal requests

(4) copies of written notices of denial of requests for expedited Appeal resolution;

(5) date of acknowledgement of written standard Appeal requests and method of acknowledgment (orally or in writing);

(6) copies of written notices when extending the time frame for adjudicating standard or expedited Appeals when the Contractor initiates the extension;

(7) copies of written Notice of Appeal Resolution; and

(8) any other pertinent documentation needed to maintain a complete record of all Appeals and to demonstrate that the Appeals were adjudicated according to the Contract provision governing Appeals.

### **8.7.3 Document Maintenance, Grievances**

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

(1) date the Grievance was received;

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

(3) name of the person taking the Grievance;

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

(5) name of person resolving the Grievance; and

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

(B) The Contractor shall maintain all written Grievances and copies of the written notices of resolution to the affected parties.

## **Article 9 – Enrollee Rights and Protections**

### **9.1 Written Information on Enrollee Rights and Protections**

#### **9.1.1 General Requirements**

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

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

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

(D) The Contractor shall ensure Enrollees are free to exercise their rights, and that the exercise of those rights shall not adversely affect the way the Contractor and its Providers treat Enrollees.

#### **9.1.2 Specific Enrollee Rights and Protections**

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

- (1) the right to receive information about this Health Plan;
- (2) the right to be treated with respect and with due consideration for his or her dignity and privacy;
- (3) the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
- (4) the right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment;
- (5) the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- (6) if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.524 and 42 CFR 154.526;
- (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 CONTRACTOR and its providers.

## **9.2 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 be prohibited from advising or advocating on behalf of the Enrollee for the following:

- (1) the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- (2) any information the Enrollee needs in order to decide among all relevant treatment options;
- (3) the risks, benefits, and consequences of treatment or non-treatment; and
- (4) the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

## **9.3 Objection to Services on Moral or Religious Grounds**

### **9.3.1 Generally**

(A) Subject to the information requirements of Section 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 Section 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.

## **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, disability, 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, disability, or age.

#### **10.1.2 Member Services Function**

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

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

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

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

(2) assisting Enrollees to select or change Primary Care Providers; and

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

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

#### **10.1.3 Provider Services Function**

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

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

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

#### **10.1.4 Enrollee Liability**

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

- (1) The debts of the Contractor if it should become insolvent.
- (2) Payment for services provided by the Contractor if the Contractor received payment from the Department for the services or if the provider, under contract with the Contractor, fails to receive payment from the Contractor.
- (3) The payments to providers that furnish Covered Services under a contract or other agreement with the Contractor that are in excess of the amount that normally would be paid by the Enrollee if service had been received directly from the Contractor.

## **10.2 Contractor Assurances Regarding Access**

### **10.2.1 Documentation Requirements**

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

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

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

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

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

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

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

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

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

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

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

### **10.2.3 Interpretive Services**

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

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

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

#### **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 Providers which respect Enrollees' cultural backgrounds.

(C) The Contractor shall foster cultural competency among its Providers. Culturally competent care is care given by a 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 Providers provide culturally sensitive services to Enrollees. These services shall include but are not limited to providing training to 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 contracting Providers acting within his or her scope of practice, shall be permitted to freely advise an Enrollee about his or her health status and discuss appropriate medical care or treatment for that condition or disease regardless of whether the care or treatment is a Covered Service.

#### **10.2.6 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 doctor's office)

(B) These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every month.

## **10.3 Coordination and Continuity of Care**

### **10.3.1 In General**

(A) The Contractor shall ensure access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities.

(B) The Contractor shall implement procedures to coordinate the services the Contractor furnishes to the Enrollee with the services the Enrollee receives from any other MCO, PIHP, or PAHP.

(C) 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.

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

### **10.3.2 Primary Care**

(A) The Contractor shall implement procedures to deliver Primary Care to and coordinate health care services for all Enrollees.

(B) The Contractor shall implement procedures to ensure that each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee.

(C) The Contractor shall allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes clients who are under the Restriction Program.

(D) If an Enrollee's Primary Care Provider ceases to participate in the Contractor's network, the Contractor shall offer the Enrollee the opportunity to select a new Primary Care Provider.

### **10.3.3 Prepaid Mental Health Plan**

(A) When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the Contractor and Prepaid Mental Health Plan shall share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

(B) The Contractor shall educate its Providers regarding an effective model of coordination between physical and mental health care services. The Contractor shall ensure its Providers coordinate the provision of physical health care services with mental health care services as appropriate.

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

(D) Clients enrolled in the Health Plan and a Prepaid Mental Health Plan who due to a psychiatric condition require lab, radiology and similar outpatient services covered under this Contract, but prescribed by the Prepaid Mental Health Plan physician, shall have access to such services in a timely fashion. The Contractor and Prepaid Mental Health Plan shall reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

## **10.4 Restriction Program**

### **10.4.1 Restriction Program, Generally**

(A) The Contractor shall develop policies and procedures that the Contractor will use to manage Enrollees who are placed on the Restriction Program. The Contractor's policies and procedures must be approved by the Department.

(B) The Contractor shall use the Department's criteria for determining which of its Enrollees are eligible for the Restriction Program.<sup>4</sup>

(C) When an Enrollee is placed on the Restriction the restriction will take effect after the Enrollee's Medical Benefit Card has been printed.

(D) The Contractor shall provide to the Department, on a daily basis, and in a Department specified format, a list of Enrollees who the Contractor has determined to be eligible for the Restriction Program.

(E) When placing an Enrollee on the Restriction Program, the Contractor shall provide written notice to the Enrollee that the Enrollee is being placed on the Contractor's Restriction Program. The written notice shall include:

(1) The reason why the Enrollee is being placed on the Restriction Program;

(2) The Enrollee's right to file an Appeal with the Contractor using the Contractor's internal grievance procedures; and

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<sup>4</sup>DRAFT CONTRACT NOTE: The Department currently has criteria for Enrollees to be placed on the restriction program. The Department will invite the Plans to provide input on the criteria.

(3) The time frame in which the Enrollee must file an Appeal with the Contractor.

(F) Once the Enrollee has exhausted the Contractor's internal Appeals Process, the Contractor shall inform the Enrollee of his or her right to a State Fair Hearing and the timeframe in which the Enrollee must file a Request for a State Fair Hearing. The Contractor shall appear at the State Fair Hearing and defend the restriction. In the event that the Contractor fails to appear at the hearing, the Enrollee's Appeal will be automatically approved.

#### **10.4.2 Restriction Program Requirements**

(A) The Contractor shall provide care coordination for its Restricted Enrollees.

(B) The Contractor shall provide staff who shall ensure that all Enrollees who are on the Restriction Program have a contact person to call when they have access problems, physician or pharmacy change requests, or other questions or problems.

(C) Once an Enrollee is placed on the Restriction Program, the Contractor shall provide the following services related to the Restriction Program:

- (1) Provide the Enrollee an initial orientation about the Restriction Program and ongoing education on the appropriate use of medical services;
- (2) Ensure access to necessary care, including urgent care and emergent care;
- (3) Maintain a standardized care coordination & Restriction plan (in conjunction with the Enrollee's Primary Care Provider). The Contractor shall provide such plans to the Department upon request.

(D) The Contractor shall ensure that Enrollees who are on the Restriction Program are linked to a PCP who agrees to serve as a Restriction PCP. The Restriction PCP shall agree to the following:

- (1) Manage all of the Enrollee's medical care;
- (2) Educate the Enrollee regarding the appropriate use of medical services;
- (3) Provide a referral to another physician when needed care is not within the PCP's field of expertise, or when for some other reason the care cannot be provided by the PCP;
- (4) Shall be telephonically available 24 hours a day, seven days a week (or make certain a provider of comparable specialty is available) for urgent/emergent medical situations to assure the availability of prompt, quality, medical services and continuity of care;
- (5) Manage acute and/or chronic long term pain through a variety of services or treatment options including office calls, medication administration, physical therapy, counseling and mental health referral with emphasis on teaching Enrollees to manage their pain by

adapting actions and behaviors;

(6) Approve or deny drugs prescribed by other providers when contacted by the pharmacy to which the Enrollee is restricted;

(7) Work with the Restriction pharmacy, specialists, dentists, etc. sharing pertinent information regarding the Enrollee; and

(E) If the Restricted Enrollee's PCP chooses to no longer serve as the Enrollee's PCP, the Contractor shall assist the Enrollee in finding a new PCP.

(F) If the Restricted Enrollee becomes eligible for Fee For Service, the Contractor shall coordinate with the Department to ensure continuity of care for the Enrollee.

(G) In the event that the Contractor fails to properly manage a restricted enrollee as required by this Contract the Department shall pay the Contractor the non-restricted rate cell for the Enrollee.

## **10.5 Billing Enrollees**

### **10.5.1 Enrollee Billing, Generally**

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

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

### **10.5.2 Circumstances in Which an Enrollee May Be Billed**

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

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

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

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

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

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

### **10.5.3 Prohibition on Holding Enrollee's Medicaid Card**

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

### **10.5.4 Criminal Penalties**

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

## **10.6 Survey Required**

### **10.6.1 General Requirements**

- (A) Surveys shall be conducted of Contractor's 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)

## **10.7 CHEC Requirements**

### **10.7.1 General CHEC Requirements**

The Contractor shall act as a continuing care provider for the CHEC/EPSTDT program in compliance with OBRA 1989 and Sections 1902(a)(43), 1905(a)(4)(B) and 1905(r) of the Social Security Act.

## **Article 11 Measurement and Improvement Standards**

### **11.1 Provider Practice Guidelines**

#### **11.1.1 Provider Practice Guidelines, General Standards**

(A) The Contractor and its 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 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.

### **11.2 Quality Assessment and Performance Improvement Program**

#### **11.2.1 Quality Assessment and Performance Improvement, Generally**

(A) The Quality Assessment and Performance Improvement Program shall include a policymaking body which oversees the Quality Assessment and Performance Improvement Program, 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.

(B) The Contractor shall establish an ongoing quality assessment and performance improvement program for the services it furnished to Enrollees. 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.

### **11.2.2 Basic Elements of Quality Assessment and Performance Improvement Programs**

(A) At minimum, the Contractor shall comply with the following requirements:

- (1) Conduct PIPs that are 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 health outcomes and Enrollee satisfaction;
- (2) Submit performance measurement data;
- (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; and
- (5) Have in effect a process for evaluating the impact and effectiveness of the quality assessment and performance improvement program.

### **11.2.3 Performance Measurement**

(A) Annually, the Contractor shall:

- (1) Measure and report to the Department its performance, using standard measures required by the Department and/or CMS;
- (2) Submit to the Department data specified by the Department that enables the Department to measure the Contractor's performance; or
- (3) Perform a combination of the above activities.

### **11.2.4 Required Areas and Reporting of Performance Improvement Projects**

(A) The Contractor shall have ongoing PIPs that focus on clinical and non-clinical areas, and that involve the following:

- (1) Measurement of performance objectives using objective quality indicators;
- (2) Implementation of system interventions to achieve improvement in quality;
- (3) Evaluation of effectiveness of the interventions; and
- (4) Planning and initiation of activities for increasing or sustaining improvement.

(B) The Contractor shall report the status and results of each project, including those required by CMS, to the Department as requested.

(C) Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. The Department may also, at its discretion, set up a timeframe and deadline for the Contractor to complete a PIP.

### **11.2.5 HEDIS and Consumer Satisfaction Surveys**

(A) Audited Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance measures shall be reported as set forth in Utah Administrative Code R428-12-1, *et seq.*, and R428-13-1, *et seq.*

(B) The Contractor shall assign a staff member to attend an annual HMO Advisory Committee meeting as convened by the Office of Health Care Statistics to discuss the HEDIS reviews and consumer satisfaction survey results.

(C) For purposes of HEDIS measures and consumer satisfaction surveys, the calculations and results shall include both Traditional and Non-Traditional Enrollees.

(D) In the event that the Contractor experiences a 10% decline in its HEDIS measures or customer satisfaction surveys from the previous year, the Department will require the Contractor to develop and implement a corrective action plan.

## **Article 12 Payments**

### **12.1 General Payment Provisions**

#### **12.1.1 Risk Contract**

This Contract is a Risk Contract.

#### **12.1.2 Payment Methodology**

The payment methodology is described in Attachment F 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.

## **12.2 Medicare**

### **12.2.1 Payment of Medicare Part B Premiums**

(A) The Department shall pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee shall assign to the Contractor his or her Medicare reimbursement for benefits received under Medicare.

(B) The Department shall identify on the Eligibility Transmission the Enrollees who are covered under Medicare.

### **12.2.2 Payment of Services Covered by Medicare**

(A) The Contractor's payment for Medicare crossover claims shall be the allowed Contractor's payment rate less any amounts paid by Medicare and other payors.

(B) When a service is paid for by Medicare, the contractor shall pay in accordance with 12.2.2(A) of this Contract whether or not the service is covered under this Contract.

(C) The Contractor is responsible for payment whether or not the Medicare covered service is rendered by a network Provider or has been authorized by the Contractor.

(D) The Costs that the Contractor paid for providing care for Enrollees who are also covered Medicare shall be reported in Attachment E, Table 2.

### **12.2.3 Prohibition on Balance Billing**

The Contractor shall ensure its Providers will not balance bill the Enrollee. The reimbursement from Medicare and from the Contractor shall be payment in full.

## **12.3 Third Party Liability and Coordination of Benefits**

### **12.3.1 Recovery of Third Party Liability, Generally**

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

### **12.3.2 Policies and Procedures for Third Party Liability Recovery**

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

- (1) Procedures and Mechanisms to identify potentially liable Third Parties;
- (2) Procedures and Mechanisms to identify the amount owed by a Third Party; and
- (3) Procedures and Mechanisms for recovery of Third Party Liability payments.

### **12.3.3 Pay and Chase and Cost Avoidance**

(A) Except as otherwise provided in Section 12.3.3(B) of this Contract, when the Contractor is aware of the probable existence of Third Party Liability at the time a claim from a provider is filed with the Contractor:

- (1) The Contractor must reject the claim and return it to the provider for a determination of the amount of liability.
- (2) The establishment of third party liability takes place when the Contractor receives confirmation from the provider or a third party resource indicating the extent of third party liability.
- (3) When the amount of liability is determined, the contractor must then pay the claim to the extent that payment allowed under the Contractor's payment schedule exceeds the amount of the third party's payment.

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

- (1) the claim is prenatal care for women, or preventative pediatric services (including early and periodic screening, diagnosis and treatment services provided for under 42 CFR 441, Part B), and is covered under the State Plan;
- (2) the claim is for a service covered under the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. In this instance the Contractor must pay the provider if, after 30 days, it has not received payment from the individual.

(C) If the probable existence of Third Party Liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the Contractor must pay the claim pursuant to its payment schedule. When the Contractor

determines that Third Party Liability exists the Contractor must seek reimbursement from the third party within 60 days of discovery of the Third Party Liability.

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

(D) Contractor shall keep payment of TPL. The Contractor shall report any Third Party Liability Recoveries on the 837 File.

## **12.4 Personal Injury Cases**

### **12.4.1 Notification of Personal Injury Cases**

(A) The CONTRACTOR shall be responsible to notify the Office of Recovery Services (ORS) of all personal injury cases, pursuant to Utah Code Ann. §26-19-1, *et seq.*, no later than 30 days after the CONTRACTOR has received a “clean” claim. A clean claim is a claim that is ready to adjudicate. The diagnosis codes to identify personal injury cases include the ICD-9-CM codes 800 through 999 (regardless of any prefix, e.g. E800) except the following codes: 900-919.5, 931-939.9, 942.22, 944.20, 946.2, E950-958.8, 958.3, 960-979.9, 981, 986, 989.5, 990-995.89, 996-998.9, and 999.8.

(B) The following data elements shall be provided by the Contractor to ORS:

- (1) patient name and Medicaid Identification number;
- (2) Contractor’s patient number;
- (3) dates of service;
- (4) provider billed amount;
- (5) TPL collected amount;
- (6) TPL name;
- (7) amount paid by Contractor;
- (8) amount paid by Medicaid;
- (9) servicing provider name;
- (10) specific type of injury by ICD-9-CM code; and
- (11) procedure codes.

(C) ORS shall pursue the personal injury collections and submit all collections to the Department.

## **12.5 Contractor's Payment Responsibilities**

### **12.5.1 Covered Services Received Outside Contractor's Network but Paid by the Contractor**

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

- (1) Emergency Services;
- (2) Court ordered services that are Covered Services defined in Attachment C; or
- (3) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unable from the Contractor.

### **12.5.2 Payment to Non-Network Providers**

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

- (1) The usual charges made to the general public by the provider;
- (2) The rate equal to the applicable Medicaid fee-for-service rate; or
- (3) The rate agreed to by the Contractor and the provider.

### **12.5.3 Covered Services which are Not the Contractor's Responsibility**

(A) The Contractor is not responsible for payment when family planning services are obtained by an Enrollee from sources other than the contractor.

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

(C) The Contractor shall not be required to pay for Covered Services provided to American Indian Enrollees who receive services are provided by Indian health care providers. Such services shall be paid by the Department. Indian health care provider means an Indian Health

facility, a Tribal Program or an Urban Indian Organization.

(D)The Contractor shall not be responsible to for payment for equipment related to sleep apnea or oxygen concentrators.

#### **12.5.4 Department Responsibility for Payment**

Except as described in Attachment F or otherwise by this Contract, the Department shall not be required to pay for any Covered Services under Attachment C which the Enrollee receives from any source outside of the Contractor except for family planning services.

#### **12.5.5 Covered Services Provided by the Utah Department of Health, Division of Family Health and Preparedness**

(A) For Enrollees who qualify for special services offered by or through the Department of Health, Division of Family and Health Preparedness (“DFHP”), the Contractor agrees to reimburse DFHP at the standard Medicaid rate in effect at the time of service for one outpatient team evaluation and one follow-up visit for each Enrollee upon each instance that the Enrollee becomes a Medicaid Eligible Individual and selects the Contractor as its Health Plan.

- (1) The Contractor agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit.
- (2) The services provided in the outpatient team evaluation and follow-up visit for which the Contractor shall reimburse DFHP are limited to the services that the Contractor is otherwise obligated to provide under this Contract.

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

#### **12.5.6 Administrative Fee for Immunizations**

When an Enrollee under the age of 19 has third party coverage for immunizations, the Contractor shall pay the provider the administrative fee for providing the immunization and not require the provider to bill the third party. The Contractor may choose to pursue the third party for the administrative fee after the payment has been made to the provider.

### **12.6 Enrollee Transition Between Health Plans or Fee-For-Service**

#### **12.6.1 Plan Transitions, Inpatient Hospital Stays**

(A) When an Enrollee is in an inpatient hospital setting and selects another Health Plan or becomes fee-for-service any time prior to discharge from the hospital, the Contractor is financially responsible for the entire hospital stay including all services related to the hospital

stay.

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

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

(D) If a Medicaid Eligible Individual is fee-for-service when discharged from the hospital, the Department is financially responsible for the remainder of the month when the individual was discharged.

### **12.6.2 Enrollee Transition, Home Health Services**

(A) Medicaid Eligible Individuals who are under fee-for-service or are enrolled in a Health Plan other than the Contractor's Health Plan and are receiving home health services from an agency not contracting with the Contractor shall be transitioned to the Contractor's home health agency.

(B) The Contractor shall pay the Medicaid rate for services provided by an out-of-network Home Health Agency to an Enrollee until the Home Health Agency enrolls as an in-network provider with the Contractor or the Contractor provides an assessment to 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 home health agency before the transition is complete. The Contractor shall address the Enrollee's concerns regarding Covered Services provided by the Contractor's home health agency before the new plan of care is implemented.

### **12.6.3 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 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 Medicaid Eligible Individual by the Department and the Medicaid 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 either the Health Plan (or the Department if the client was Medicaid fee-for-service) in which the client is enrolled at the time the equipment is ordered.

## **Article 13 Additional Recordkeeping and Reporting Requirements**

### **13.1 Recordkeeping Requirements**

#### **13.1.1 Health Information Systems, General Requirements**

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, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

#### **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;
- (2) screening the data for completeness, logic, and consistency; and
- (3) collecting service information in standardized formats to the extent feasible and appropriate.

(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**

The Contractor shall require its 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 three (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 six (6) years. Such documents include, but are not limited to, the attestation forms required by Section 6.3.2, Contractor's policies and procedures, Contractor's member handbooks, and copies of reports required by the Department.

## **13.2 Additional Reporting Requirements**

### **13.2.1 Enrollment, Cost and Utilization Reports**

(A) The Contractor shall submit Enrollment, Cost and utilization reports in an electronic format designated by the Department. The reports shall be in Excel, and the Contractor shall utilize the Excel template provided by the Department. The Contractor is not allowed to customize or change the format of this report. The template of the report can be found in Attachment E of this Contract. The Department may amend attachment E at its discretion.

(B) The Contractor shall certify, in writing, the accuracy and completeness, to the best of its knowledge, of all cost and utilization data provided to the Department on Attachment E.

(C) Two Attachment E reports shall be submitted covering the dates of service for each Contract year. The reports shall be submitted as follows:

(1) Attachment E is due May 1 for the preceding six month reporting period (July through December).

(2) Attachment E is due November 1 for the preceding 12 month reporting period (July through June).

(D) The Contractor may request, in writing, an extension of the due date up to 30 days beyond the required due date. The Department shall approve or deny the extension request within seven calendar days of receiving the request.

### **13.2.2 Semi-Annual Reports**

(A) The following semi-annual reports are due May 1 for the preceding six month reporting

period ending December 31 (July through December) and are due November 1 for the preceding six month period ending June 30 (January through June):

- (1) A report of the number of organ transplants by type of transplant;
- (2) A report of obstetrical information including:
  - (i) the total number of obstetrical deliveries by aid category grouping;
  - (ii) the total number of caesarean sections and total number of vaginal deliveries;
  - (iii) the total number of low birth weight infants; and
  - (iv) the total number of Enrollees requiring prenatal hospital admission.
- (3) The Grievance and Appeals reports required by Section 8.7.1 of this Contract.

### **13.2.3 Reporting of Abortions, Sterilizations, and Hysterectomies**

(A) The Contractor shall conduct an annual audit of abortion, hysterectomy and sterilization procedures performed by the Contractor's providers. The purpose of the audit is to monitor compliance with federal and state requirements for the reimbursement of these procedures under Medicaid rules and regulations. The Contractor shall audit all abortions and a sample of hysterectomy and sterilization procedures as defined by the Department.

(B) On November 1 of each year, the Contractor shall submit to the Department the following information on the results of the abortion, sterilization and hysterectomy audit for the previous calendar year.

(C) For the sterilization and hysterectomy audit, the Contractor shall submit documentation of the methodology used to pull the sample of sterilization and hysterectomies and include the sampling proportions.

(D) In an Excel file the Contractor shall submit the following information for all abortions, the sample of sterilizations, and the sample of hysterectomies:

- (1) client name
- (2) Medicaid ID number
- (3) procedure code
- (4) date of service
- (5) history/physical (yes/no)
- (6) operative report (yes/no)
- (7) pathology report (yes/no)
- (8) consent form (yes/no)
- (9) for hysterectomies only, medical necessity criteria

(E) The Department shall evaluate the results of the Contractor's audit and identify the cases that shall require medical record submission.

(1) Medical record submission shall be required for all abortions and a random sample of hysterectomy and sterilization cases.

(2) The Department shall notify the Contractor in writing of the cases that shall require medical record submission and the timeline for the medical record submissions.

#### **13.2.4 Provider Network Reports**

The Contractor shall submit a monthly electronic file of its Provider network 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 August 1 of each year. (See Attachment D).

#### **13.2.6 Development of New Reports**

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

### **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 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 data to the Department in accordance with the Department's Encounter Records 837 Institutional Guide and the 837 Professional Companion Guide, as amended.

(D) The Contractor shall submit Encounter data at least once per calendar month. The Encounter Data must represent all Encounter Claim types (medical and institutional) received and adjudicated by the Contractor that Month.

(E) The Contractor shall submit all initial and unduplicated Encounter Data to the Department within 180 days of the date of service. The Department may require corrective action if more than 10% of the Encounter Claims submitted are over 180 days after the date of service or known exact duplicate claims exceed 10% per month.

(F) The Department will edit Encounter Data in accordance with the 837 companion guide. Encounters with incomplete data or incorrect codes will be rejected.

(G) The Department will notify the Contractor of the status of rejected Encounter Data by sending a 277 Health Care Claim Status Response Transaction to the Contractor's UHIN mail box. The Contractor shall be responsible for reviewing 277 transactions and taking appropriate action when necessary.

(H) The Contractor shall submit corrections to all rejected encounters within 90 days of the date the Department sends notice that the Encounter is rejected.

(I) The Contractor shall submit Encounter Data for all services rendered to Medicaid enrollees under this contract, including Encounters where the Contractor determined no liability exists. The Contractor shall submit Encounter Data even if the Contractor did not make any payment for a Claim, including Claims for services to Medicaid enrollees provided under a subcontract, capitation or special arrangement with another facility or program. The Contractor shall submit Encounter Data for all services provided under this Contract to Medicaid Enrollees who also have Medicare coverage, if a claim was submitted to the Contractor.

(J) If the Contractor discovers that services and/or costs of Excluded Providers have been included in the Encounter Data, the Contractor shall immediately notify the Department and correct the Encounter data.

### **13.3.2 Encounter Data Certification**

(A) By electronically submitting its Encounter Data to the Department, the Contractor is certifying that the Encounter Data in accordance with 42 CFR 438.606.

(B) By electronically submitting its Encounter Data to the Department, the Contractor ensures that the data has been certified the data by one of the following:

- (1) the Contractor's Chief Executive Officer;
- (2) the contractor's Chief Financial Officer; or
- (3) an individual who has delegated authority to sign for, and who reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer.

(C) By electronically submitting the Encounter Data to the Department the Contractor ensures that the person certifying the encounter data attests to the completeness and truthfulness of the data and documents based on the person's best knowledge, information, and belief.

### 13.3.3 All Payor Claims Database

## **13.4 Disallowance of Claims**

### **13.4.1 Procedures for Disallowance or Overpayments**

(A) In the event that the Contractor, the Department, CMS or any other entity identifies a disallowance or an overpayment, the Contractor and the Department shall collect the overpayment or disallowance from the Provider and shall correct the encounter data within 30 days of the recovery.

(B) The Contractor shall collect any disallowance or overpayment from the provider within 12 months of the date of discovery of the disallowance or overpayment.

(C) The Contractor shall reverse the encounter(s) for the disallowed claims or the claims that have been overpaid within sixty (60) days of the date of notice of the disallowance or discovery of the overpayment. Failure to properly reverse or adjust the encounter will result in a Notice of Non Compliance pursuant to 15.1.4 and subsequent action pursuant to 15.3.2.

## **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 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.

#### **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.

#### **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 Medicaid program for "related party/home office" transactions, as defined by CMS Manual 15-1.

(B) The records described in 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 documents:

- (1) the Contractor's quality improvement program description for the current State Fiscal Year,
- (2) the Contractor's quality improvement work plan for the current State Fiscal Year, and
- (3) the Contractor's quality improvement work plan evaluation for the previous State Fiscal Year.

(B) These reports shall be in a format developed by the Department and be signed by the contractor.

(C) The reports listed in 13.1.5 shall be due on August 31 of each year.

#### **14.2.2 Quality Monitoring by the Department**

(A) The Department shall review, at least annually, the impact and effectiveness of the Contractor's quality assessment and performance improvement program. At least 60 days prior to the Department's review, the Contractor shall provide to the Department:

- (1) the Contractor's most current written quality improvement program description;
- (2) the Contractor's most current annual quality improvement work plan;
- (3) the Contractor's most current quality improvement work plan evaluation for the previous calendar year;
- (4) documentation of the Contractor's compliance with standards defined by the Department's quality monitoring strategy (found in Attachment D);
- (5) all other information requested by the Department to facilitate the Department's review of the Contractor's compliance standards defined in the Department's quality strategy (found in Attachment D).

(B) All documents submitted to the Department pursuant to 13.2.2 shall provide evidence of a well-defined, organized program designed to improve client care.

(C) The Department's review of the impact and effectiveness of the Contractor's quality assessment and performance improvement program shall also include:

- (1) The results of the Contractor's PIPs; and
- (2) The Contractor's compliance with the Department's quality strategy (found in Attachment D).

### **14.3 External Quality Review**

#### **14.3.1 External Quality Review, Generally**

(A) Pursuant to 42 CFR Part 438, Subpart E, the Department shall arrange for EQRs to assess Contractor's management of quality, timeliness, and access to Covered Services.

(B) The Contractor shall maintain, and make available to the EQRs, all clinical and administrative records for use in EQRs.

(C) The Contractor shall support any additional quality assurance reviews, focused studies, or other projects that the Department may require as part of EQRs.

### **14.3.2 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.

### **14.3.3 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 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.

### **14.3.4 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 Department shall review requests from the Contractor for extensions of these timeframes and shall approve or disapprove the request.

## **14.4 Utah Office of the Inspector General**

### **14.4.1 General Requirements**

(A) The Contractor shall cooperate with the Utah OIG in any performance or financial audit Medicaid funds received by the Contractor as allowed by Utah Code Ann. §63J-4a-202(2).

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

(2) The Utah OIG shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual criteria published by McKesson Corporation, or another suitable industry standard substitute in accordance with Utah Administrative Code R367-1-7(3)(b).

(B) The Contractor shall provide to the Utah OIG any record requested by the Utah OIG pursuant to Utah Code Ann. §63J-4a-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. §§63J-4a-302, 303.

(D) In accordance with Utah Code Ann. §63J-4a-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. §63J-4a-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 program standards, performance standards, or any term of 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. If the Contractor fails to satisfactorily complete the Department's Corrective Action Plan, the Department may assess liquidated damages in accordance with Article 14 of this Contract.

(C) If the Contractor disagrees with the Department's Corrective Action Plan, the Contractor may file a Request for a State Fair Hearing within 30 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 business days from the date the Department's notice was mailed to submit a corrective action plan to the Department for its approval.

(C) The Department shall notify the Contractor of its approval of the Contractor's corrective action plan within 20 days of receipt. In the event that the Department determines that the Contractor's corrective action plan needs to be revised, the Department shall provide instructions to the Contractor on how the plan needs to be revised

(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 15.3 of this Contract.

### **15.1.4 Notice of Non-Compliance**

(A) In the event that the Contractor fails to comply with program standards, performance standards, or any term of 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.

(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's imposition of any of the Sanctions described in 14.1.1(B) is not intended to be an exclusive remedy available to the Department. The assessment of any of the sanctions listed in 14.1.1(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) The Department may suspend Contractor's Capitation Payment in the event that the Contractor fails to comply with any provision of this Contract.
- (B) The Department may suspend the Contractor's Capitation Payment for any failure to submit or comply with a corrective action plan within the timeframes required by the Department.

### **15.2.2 Procedure for Capitation Payment Suspension**

- (A) The Department will 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.
- (B) If the Contractor disagrees with the reason for the suspension of the Capitation Payments, the Contractor may request a State Fair Hearing within the applicable timeframes. The Department may continue to withhold Capitation Payments through the duration of the State Fair Hearing, unless ordered by the State Fair Hearing Office 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 chose to impose liquidated damages, the Parties agree that the following damages provisions represent a reasonable estimation of the damages that would be suffered by the Department due to the Contractor's failure to perform. Such damages to the Department would include additional costs of inspection and oversight incurred by the Department, due to Contractor's non-performance or late performance of any provision of this Contract.
- (C) At its discretion, the Department may withhold damages from the Department's Capitation Payment to the Contractor.

### **15.3.2 Liquidated Damages, 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 requested documents to the Department;
- (2) \$400 per calendar day the Contractor fails to submit required reports to the Department;
- (3) \$1,000 per calendar day the Contractor fails to submit encounter data or the post adjudication pharmacy file
- (4) \$500 per calendar day the Contractor fails to submit or comply with corrective action plan
- (5) \$500 per calendar day for any other breach requiring 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 Contractor acts or fails to act as follows:

- (1) Fails substantially to provide Medically Necessary services that the Contractor is required to provide, under law or under this Contract with the Department, to an Enrollee covered under this Contract;
- (2) Imposes on Enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- (3) Acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a client, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future medical services;
- (4) Misrepresents or falsifies information that it furnishes to CMS or the Department;
- (5) Misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or 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 misleading information.

(8) Has violated any of the other applicable requirements of Section 1903(m) or Section 1932 of the Social Security Act and its Implementing Regulations.

#### **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 14.4.2. The notice shall explain the basis and the nature of the sanction.

(B) The Contractor has 30 days to provide a written response to the Department.

(C) 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 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 (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in Section 1903(m) of the Social Security Act, or 42 CFR 438 Subpart I.

(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 to provide a hearing before imposing this sanction.

#### **15.4.7 Duration of Temporary Management**

The Department may not terminate temporary management until it determines that the Contractor can ensure that the sanctioned behavior shall not occur.

#### **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 Automatic and Without Cause Termination**

##### **16.1.1 Automatic Termination**

This Contract shall automatically terminate on June 30, 2016.

##### **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 days prior to the termination date. The termination notice must be on the first working day of the month with the termination effective no later than the first day of the third month following the Contractor's written notice.

(B) The Department may terminate this Contract without cause upon 30 days written notice.

### **16.1.3 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 thirty days following termination, whichever occurs first.

(B) If the Contractor or one of its subcontractors becomes insolvent or bankrupt, the Enrollees shall not be liable for the debts of the Contractor or its Subcontractor.

## **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 Medicaid benefits through other options included in the State Plan, if the Department determines that the Contractor has failed to:

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

### **16.2.2 Pre-Termination Hearing**

(A) In accordance with 42 CFR 738.710, before terminating the Contract pursuant to Section 15.2.1 of this Contract, the Department must provide the Contractor with a pre-termination hearing. The Department shall:

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

(B) In accordance with 42 CFR 438.722, after the Department notifies the Contractor that it intends to terminate the Contract, the Department may give Enrollees written notice of the

Department's intent to terminate the Contract and may allow Enrollees to disenroll immediately, without cause.

### **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.

## **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 Medicaid 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 Department's policies and procedures in Provider Manuals and Medicaid Information Bulletins, and shall ensure that the Contractor and its 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.

#### **17.1.9 Release from Liability**

(A) The Contractor releases the Department from liability for any damages that may occur to the Contractor in the event that any electronic transmission or electronic file which the Department sends to the Contractor pursuant this Contract contains errors or is not sent to the Contractor pursuant to the timelines provided for in this Contract.