UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2006

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One Golden Shore Drive, Long Beach, California	**90802**
(Address of principal executive offices)	(Zip Code)

(562) 435-3666
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o Accelerated filer ☒ Non-accelerated filer o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No ☒

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of May 8, 2006, was 27,935,134.

MOLINA HEALTHCARE, INC.

Index

Part I – Financial Information

Item 1. Financial Statements

Condensed Consolidated Balance Sheets as of March 31, 2006 (unaudited) and December 31, 2005

Condensed Consolidated Statements of Income for the three month periods ended March 31, 2006 and 2005 (unaudited)

Condensed Consolidated Statements of Cash Flows for the three month periods ended March 31, 2006 and 2005 (unaudited)

Notes to Condensed Consolidated Financial Statements (unaudited)

Item 2. **Management's Discussion and Analysis of Financial Condition and Results of Operations**

Item 3. **Quantitative and Qualitative Disclosures About Market Risk**

Item 4. **Controls and Procedures**

Part II - Other Information

Item 1. **Legal Proceedings**

Item 1A. **Risk Factors**

Item 4. **Submission of Matters to a Vote of Security Holders**

Item 6. **Exhibits**

Signatures

PART I - FINANCIAL INFORMATION

Item 1: Financial Statements.

MOLINA HEALTHCARE, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS
(amounts in thousands, except share data)

	March 31, 2006 (unaudited)	December 31 2005
ASSETS		
Current assets:		
Cash and cash equivalents	$ 288,347	$ 249,203
Investments	101,690	103,437
Receivables	73,884	70,532
Income tax receivable	—	3,014
Deferred income taxes	3,039	2,339
Prepaid and other current assets	9,615	10,321
Total current assets	476,575	438,846
Property and equipment, net	32,716	31,794
Goodwill and intangible assets, net	122,893	124,914
Restricted investments	18,205	18,242
Other assets	8,804	8,018
Total assets	$ 659,193	$ 621,814
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 235,579	$ 217,354
Accounts payable and accrued liabilities	29,670	31,457
Deferred revenue	6,248	803
Income taxes payable	3,588	—
Total current liabilities	275,085	249,614
Deferred income taxes	3,657	4,796
Other long-term liabilities	4,488	4,554
Total liabilities	283,230	258,964
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 27,935,134 shares at March 31, 2006 and 27,792,360 shares at December 31, 2005	28	28
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	167,235	162,693
Accumulated other comprehensive loss	(648)	(629)
Retained earnings	229,738	221,148
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	375,963	362,850
Total liabilities and stockholders' equity	$ 659,193	$ 621,814

See accompanying notes.

CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(amounts in thousands, except per share data)
(unaudited)

	Three months ended March 31	
	2006	2005
Revenue:		
Premium revenue	$ 449,294	$ 392,187
Investment income	4,082	1,765
Total revenue	453,376	393,952
Expenses:		
Medical care costs:		
Medical services	74,858	63,667
Hospital and specialty services	262,870	226,532
Pharmacy	45,519	42,915
Total medical care costs	383,247	333,114
Salary, general and administrative expenses	51,213	33,546
Depreciation and amortization	4,762	3,198
Total expenses	439,222	369,858
Operating income	14,154	24,094
Other expense:		
Interest expense	(414)	(289)
Total other expense	(414)	(289)
Income before income taxes	13,740	23,805
Provision for income taxes	5,150	9,046
Net income	$ 8,590	$ 14,759
Net income per share:		
Basic	$ 0.31	$ 0.53
Diluted	$ 0.31	$ 0.53
Weighted average shares outstanding:		
Basic	27,855	27,616
Diluted	28,141	27,964

See accompanying notes.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)
(unaudited)

	Three months ended March 31	
	2006	2005
Operating activities		
Net income	$ 8,590	$ 14,759
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	4,762	3,198
Amortization of credit facility fees	211	734
Deferred income taxes	(1,835)	1,472
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	—	1,021
Stock-based compensation	1,227	175
Changes in operating assets and liabilities:		
Receivables	(3,352)	(8,685)
Prepaid and other current assets	706	478
Medical claims and benefits payable	18,225	(4,645)
Accounts payable and accrued liabilities	391	(4,694)
Deferred revenue	5,445	—
Income taxes payable or receivable	6,602	(1,374)
Net cash provided by operating activities	40,972	2,439
Investing activities		
Purchases of equipment	(3,663)	(2,189)
Purchases of investments	(34,015)	(3,969)
Sales and maturities of investments	35,739	18,935
(Increase) decrease in restricted cash	37	(41)
Increase (decrease) in other long-term liabilities	(66)	366

Increase in other assets	(997)	(4,633)
Net cash provided by (used in) investing activities	(2,965)	8,469
Financing activities		
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	467	—
Proceeds from exercise of stock options and employee stock purchases	670	386
Borrowings under credit facility	—	3,100
Principal payments on capital lease obligation and mortgage note	—	(40)
Net cash provided by financing activities	1,137	3,446
Net increase in cash and cash equivalents	39,144	14,354
Cash and cash equivalents at beginning of period	249,203	228,071
Cash and cash equivalents at end of period	$ 288,347	242,425
Supplemental cash flow information		
Cash paid during the period for:		
Income taxes	$ 1	7,922
Interest	$ 414	226
Schedule of non-cash investing and financing activities:		
Change in unrealized gain on investments	$ (23)	$ (382)
Deferred taxes	4	147
Change in net unrealized gain on investments	$ (19)	(235)
Value of stock issued for employee compensation earned in previous year	$ 2,178	$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(amounts in thousands, except share data)
(unaudited)
March 31, 2006

1. The Reporting Entity

Molina Healthcare, Inc. (the Company) is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. We were founded in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we began operating as a health maintenance organization (HMO). We operate our HMO business through subsidiaries in California (California HMO), Indiana (Indiana HMO), Michigan (Michigan HMO), New Mexico (New Mexico HMO), Ohio (Ohio HMO), Utah (Utah HMO) and Washington (Washington HMO).

2. Basis of Presentation

The unaudited condensed consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2005. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2005 audited financial statements have been omitted. These unaudited condensed consolidated interim financial statements should be read in conjunction with our December 31, 2005 audited financial statements.

The condensed consolidated financial statements include the accounts of the Company and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented, which consist solely of normal recurring adjustments, have been included. All significant inter-company balances and transactions have been eliminated in consolidation. The condensed consolidated results of operations for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2006.

Stock-Based Compensation

At March 31, 2006, we had two stock-based employee compensation plans: the 2000 Omnibus Stock and Incentive Plan, and the 2002 Equity Incentive Plan. The 2000 Omnibus Stock and Incentive Plan is frozen. Common shares issued pursuant to the exercise of stock options for the three months ended March 31, 2006 and 2005 were 333,852 and 65,665, respectively.

Through December 31, 2005, we accounted for stock-based compensation under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options was reflected in net income and was measured as the excess of the market price of the Company's stock at the date of grant over the amount an employee must pay to acquire the stock. At December 31, 2005, we had adopted the disclosure provisions required by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*.

In December 2004, the Financial Accounting Standards Board (FASB) issued SFAS No. 123R, *Share-Based Payment*. SFAS No. 123R is a revision of SFAS No. 123, and supersedes APB 25. Among other items, SFAS 123R eliminates the use of APB 25 and the intrinsic value method of accounting, and requires companies to recognize in the financial statements the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards. SFAS 123R permits companies to adopt its requirements using either a "modified prospective" method or a "modified retrospective" method. Under the "modified prospective" method, compensation cost is recognized in the financial statements beginning with the effective date, based on the requirements of SFAS 123R for all share-based payments granted after that date, and based on the requirements of SFAS 123 for all unvested awards granted prior to the effective date of SFAS 123R. Under the "modified retrospective" method, the requirements are the same as under the

"modified prospective" method, but entities are also permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS 123.

Effective January 1, 2006, we adopted SFAS 123R using the modified prospective method. Our adoption of SFAS 123R reduced net income for the quarter ended March 31, 2006 by approximately $509, or $.02 per basic and diluted share.

The following table illustrates the effect on net income and earnings per share as if we had applied the fair value recognition provisions to stock-based employee compensation permitted by SFAS No. 148 for the three months ended March 31, 2005:

	Three months ended March 31, 2005
Net income, as reported	$ 14,759
Reconciling items (net of related tax effects):	
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for all awards	—
Deduct: Stock-based employee compensation expense determined under the fair-value based method for all awards	(237)
Net adjustment	(237)
Net income, as adjusted	$ 14,522
Earnings per share:	
Basic—as reported	$ .53
Basic—as adjusted	$ .53
Diluted—as reported	$ .53
Diluted—as adjusted	$ .52

The following table illustrates the components of our stock-based compensation expense (net of tax) for the three months ended March 31, 2006 and 2005 as reported in the Condensed Consolidated Statements of Income:

	Three months ended March 31,	
	2006	2005
Stock options	$ 509	$ —
Stock grants	257	109
Total stock-based compensation expense	$ 766	$ 109

The recognition and measurement of stock grants is the same under APB Opinion No. 25 and SFAS No. 123, *Accounting for Stock Based Compensation*. The related expenses for the fair value of stock grants were charged to salary, general and administrative expenses and are included in net income, as reported in the pro forma net income table above.

Option activity for the three months ended March 31, 2006 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (months)
Outstanding as of December 31, 2005	651,047	$ 20.98		
Granted	333,852	28.65		
Exercised	(63,472)	10.57		
Forfeited	(18,000)	44.29		
Outstanding as of March 31, 2006	903,427	$ 23.78	$ 8,420	97
Exercisable as of March 31, 2006	379,458	$ 14.01	$ 7,384	76

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following assumptions: no dividend yield; expected volatility of 53.2%; risk-free interest rate of 4.5% and expected lives of 6.0 years for the three months ended March 31, 2006. No options were granted during the three months ended March 31, 2005.

For the three months ended March 31, 2006, the expected life of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. For the three months ended March 31, 2006, expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase our common stock. The risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues.

The weighted-average fair value of options granted during the three months ended March 31, 2006 was $12.72. The total intrinsic value of options exercised during the three months ended March 31, 2006 and March 31, 2005 was $2,799 and $1,255, respectively.

Non-vested restricted stock and restricted stock unit activity for the three months ended March 31, 2006 is summarized below:

	Shares	Weighted Average

		Grant Date Fair Value
Non-vested balance as of December 31, 2005	98,497	$ 41.75
Granted	7,115	29.14
Vested	(3,315)	39.81
Forfeited	(8,000)	44.55
Non-vested balance as of March 31, 2006	94,297	$ 40.63

As of March 31, 2006 there was $5,530 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of two years.

Earnings Per Share

The denominators for the computation of basic and diluted earnings per share are calculated as follows:

	Three months ended March 31	
	2006	2005
Shares outstanding at the beginning of the period	27,792,360	27,602,000
Weighted average number of shares issued for stock options, stock grants and employee stock purchases	62,556	14,000
Denominator for basic earnings per share	27,854,916	27,616,000
Dilutive effect of employee stock options	285,854	348,000
Denominator for diluted earnings per share	28,140,770	27,964,000

New Accounting Pronouncements

In May 2005, the FASB issued Statement No. 154 (SFAS No. 154), *Accounting Changes and Error Corrections*, which replaced APB Opinion No. 20, *Accounting Changes*, and FASB Statement No. 3, *Reporting Changes in Interim Financial Statements*. SFAS No. 154 requires retrospective application to prior periods' financial statements of voluntary changes in accounting principles and changes required by a new accounting standard when the standard does not include specific transition provisions. Previous guidance required most voluntary changes in accounting principle to be recognized by including in net income of the period in which the change was made the cumulative effect of changing to the new accounting principle. SFAS No. 154 carries forward existing guidance regarding the reporting of the correction of an error and a change in accounting estimate. SFAS No. 154 is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. Adoption of SFAS No. 154 as of January 1, 2006 is not expected to have a material effect on our consolidated financial position or results of operations.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to, have a material impact on our present or future consolidated financial statements.

Reclassifications

Certain amounts for 2005 have been reclassified to conform to the 2006 presentation.

3. Loss Contract Charge

In connection with the sale by our New Mexico HMO of certain commercial employer group contracts to another health plan on August 1, 2004, our New Mexico HMO entered into a transition services agreement (the TSA). The TSA requires the New Mexico HMO to provide certain administrative services in support of the commercial membership through the date of each member group's renewal. In exchange for those services, the New Mexico HMO is compensated by the buyer at a specific amount per member per month. The New Mexico HMO entered into the TSA as an inducement to the buyer to purchase the commercial membership, and anticipated that the TSA would be unprofitable. Effective with the implementation of the TSA (August 1, 2004), the New Mexico HMO recorded a liability for the costs of the run out of the commercial business of $2,640, the bulk of which consisted of anticipated losses under the TSA. During the second quarter of 2005, that reserve was exhausted. We anticipated that we would continue to provide services under the TSA through December 31, 2005 at a net cost of $939 and recorded a loss contract charge for that amount at June 30, 2005. At March 31, 2006 only insignificant run out services remained to be performed under the TSA. A summary of activity for the net liability for termination of commercial operations for the period July 1, 2004 through March 31, 2006 follows:

Net liability for termination of commercial operations at July 1, 2004	$ 2,640
Revenue earned on transition services agreement	1,888
Costs incurred in providing transition services	(5,317)
Additional loss contract charge expensed in 2005	939
Net liability for termination of commercial operations at March 31, 2006	$ 150

4. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. Accounts receivable by operating subsidiary comprise the following:

	March 31, 2006	December 31, 2005

California HMO	$ 15,859	$ 19,952
Utah HMO	42,015	32,929
Washington HMO	6,002	7,486
Other	10,008	10,165
Total receivables	$ 73,884	$ 70,532

Substantially all receivables due our California HMO at March 31, 2006 and December 31, 2005 were collected in April and January of 2006, respectively.

Our agreement with the state of Utah calls for the reimbursement of our Utah HMO for medical costs incurred in serving our members plus an administrative fee of 9% of medical costs and all or a portion of any cost savings realized, as defined in the agreement. Our Utah HMO bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the state of Utah includes: 1) amounts billed to the state for actual paid health care claims plus administrative fees; 2) amounts estimated to be due under the savings sharing provision of the agreement; and 3) amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid.

5. Other Assets

Other assets at March 31, 2006 included an equity investment of approximately $1,600 in a medical services provider that provides medical services to the Company's members as well as deferred financing costs associated with our secured credit agreement and certain investments held in connection with our deferred employee compensation program. A liability approximately equal to the assets held in connection with our deferred employee compensation program is included in other long-term liabilities.

6. Long-Term Debt

On March 9, 2005, we entered into an amended and restated five-year secured credit agreement for a $180,000 revolving credit facility with a syndicate of lenders. The credit facility will be used for working capital purposes. This credit facility replaced the facility that we entered into on March 19, 2003.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200,000.

Borrowings under the credit facility are based, at our election, on the London interbank deposit, or LIBOR, rate or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.5% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the credit facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated EBITDA. The applicable margins range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee ranges between 0.375% and 0.500%. In addition, we will pay a fee for each letter of credit issued under the credit facility equal to the applicable margin for LIBOR loans and a customary fronting fee.

As with our prior credit facility, our obligations under the amended and restated credit facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our Indiana, Michigan, New Mexico, Utah, and Washington HMO subsidiaries, and our Molina Healthcare Insurance Company subsidiary.

The amended credit agreement includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, and investments. The credit agreement also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.00 to 1.00 at any time and a fixed charge coverage ratio

of 1.75 to 1.00 for the quarter ended March 31, 2005 and thereafter ranging from 1.20 to 1:00 for the quarter ended June 30, 2006 up to 3.00 to 1.00 for all quarters ending after December 31, 2009. At March 31, 2006, we were in compliance with all financial covenants in the credit agreement.

At March 31, 2006 and December 31, 2005, we had no balances outstanding under the credit facility.

7. Commitments and Contingencies

Legal

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly-funded programs, and the repayment of previously billed and collected revenues.

Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired Company stock between November 3, 2004 and July 20, 2005. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On March 13, 2006, the lead plaintiff filed its consolidated complaint. The consolidated complaint purports to allege claims against Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White for alleged violations of the Securities Exchange Act of 1934 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On May 1, 2006, the defendants filed a motion to dismiss the consolidated complaint for failure to state a claim upon which relief can be granted. The lead plaintiff has until June 15, 2006 to file a response to the motion to dismiss. The Class Action is in the early stages, and no prediction can be made as to the outcome.

On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of the Company against certain current and former officers and directors for

breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

Arbitration with Tenet Hospital. In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4,500 involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8,000. The parties have agreed to present their arguments in phases. The first phase of the arbitration, comprising approximately $3,000 of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1,700 by the arbitrator. We paid the award in January 2006. This amount is in addition to approximately $330 we paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. The parties are currently conducting the second phase of the arbitration. We believe that the California HMO has meritorious defenses to Tenet's claims and we intend to vigorously defend this matter. Nevertheless, at December 31, 2005, we had recorded additional expense beyond the amount of $2,030 discussed above in connection with this matter. We do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows beyond the impact of the liability recorded in connection with this matter.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named HMOs participating in the New Mexico Medicaid program as defendants, including the predecessor of the New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery has recently commenced. It is not currently possible to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6,000 in order indemnify our New Mexico

HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, $4,443 remains in the indemnification escrow fund.

Antelope Valley. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO. To date, our California HMO has not been served with the complaint. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2,001, plus interest and attorney fees. The Antelope Valley matter is in the early stages, and no prediction can be made as to the outcome.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Provider Claims

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may lead medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Subscriber Group Claims

The United States Office of Personnel Management (OPM) has contacted our New Mexico HMO seeking repayment of approximately $3,800 in premiums paid by OPM on behalf of Federal employees for the years 1999, 2000 and 2002. OPM is also seeking recovery of approximately $500 in interest in connection with this matter. OPM is asserting that it did not receive rate discounts equivalent to the largest discount given by the New Mexico HMO for Similar Sized Subscriber Groups, as required by the New Mexico HMO's agreement with OPM, during the years in question. We are evaluating the OPM claim and are unable at this time to determine either the validity of the claim or the degree, if any, of our liability in regards to this matter.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our seven HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Ohio, Utah, and Washington. Our HMOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations), which may not be transfered to us in the form of loans, advances, or cash dividends, was $167,936 at March 31, 2006 and $155,900 at December 31, 2005. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Washington, Indiana, Michigan, Ohio and Utah have adopted these rules (which vary from state to state). While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not given notice of any intention to do so. Such requirements, if adopted by California, may increase the minimum capital required by that state.

At March 31, 2006, our HMOs had aggregate statutory capital and surplus of approximately $171,800 compared with the required minimum aggregate statutory capital and surplus of approximately $118,300. All of our HMOs were in compliance with the minimum capital requirements. We have the ability

and commitment to provide additional working capital to each of our HMOs when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

8. Acquisitions

Michigan HMO (pending acquisition)

On January 26, 2006, we entered into a definitive Purchase Agreement with the shareholders of HCLB, Inc., a Michigan corporation ("HCLB"), to acquire all of the outstanding shares of HCLB capital stock. HCLB is the parent company of CAPE Health Plan, Inc., a Michigan corporation based in Southfield, Michigan. The purchase price under the Purchase Agreement is $41,600, subject to possible adjustments. In addition, as part of the purchase we will make a capital contribution to HCLB in the amount of $2,400. The Purchase Agreement is subject to customary closing conditions, including the obtaining of regulatory approval. We anticipate that the acquisition will close during the second quarter of 2006.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward Looking Statements

The information made available below and elsewhere in this quarterly report on Form 10-Q contains forward-looking statements that involve risks and uncertainties. These forward-looking statements are often accompanied by words such as "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will" and similar expressions. These statements include, without limitation, statements about our anticipated financial performance, our market opportunity, our growth strategy, competition, expected activities, future acquisitions and investments, and the adequacy of our available cash resources. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated in the forward-looking statements as a result of, but not limited to, the following factors:

- Uncertainty regarding our ability to control our medical costs and other operating expenses.
- Uncertainty regarding our ability to accurately estimate incurred but not reported medical care costs.
- Our dependence upon a relatively small number of government contracts and subcontracts for our revenue.
- Uncertainty regarding our ability to renew our government contracts.
- Government efforts to limit Medicaid expenditures.
- Uncertainty regarding high dollar claims.
- Changes to government laws and regulations or in the interpretation and enforcement of those laws and regulations.
- Difficulties we encounter in managing, integrating, and securing our information systems.
- Difficulties we encounter in executing our acquisition strategy, including obtaining the necessary government approvals and business integration difficulties.
- Ineffective management of our growth.
- The superior financial resources of our competitors.
- Restrictions and covenants in our credit facility that may impede our ability to make or finance acquisitions and declare dividends.
- The implementation of rate increases.
- Uncertainty regarding our ability to enter into more favorable provider contracts.
- Risks associated with our start-up health plans and our Medicare Advantage special needs plans.
- Uncertainty regarding membership eligibility processes and methodologies.
- Our dependence upon certain key employees.
- Our increased exposure to malpractice and other litigation risks as a result of the operation of our primary care clinics in California.
- The existence of state regulations that may impair our ability to upstream cash from our subsidiaries.

- Demographic changes or changes in utilization patterns.

- Inherent uncertainties involving pending legal or administrative proceedings.

Investors should refer to our Annual Report on Form 10-K for the year ended December 31, 2005 for a discussion of certain risk factors which could materially affect our business, financial condition, or future results. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Report on Form 10-K for the year ended December 31, 2005.

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. Our objective is to become the leading managed care organization in the United States focused primarily on serving people who receive health care benefits through state-sponsored programs for low-income populations.

We generate revenues primarily from premiums we receive from the states in which we operate. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. For the three months ended March 31, 2006, we received approximately 86.5% of our premium revenue as a fixed amount per member per month pursuant to our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These premium revenues are recognized in the month members are entitled to receive health care services. Approximately 8.0% of our premium revenue in the three months ended March 31, 2006 was realized under a cost plus reimbursement agreement that our Utah HMO has with that state. We also received approximately 5.5% of our premium revenue for the three months ended March 31, 2006 in the form of birth payments (one-time payments for the delivery of children) from the Medicaid programs in Indiana, Michigan, New Mexico, Ohio and Washington. Such payments are recognized as revenue in the month the birth occurs. The state Medicaid programs periodically adjust premium rates.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state as of the dates indicated.

Market	As of March 31, 2006	As of December 31, 2005	As of March 31, 2005
California	312,000	321,000	254,000
Indiana	28,000	24,000	—
Michigan	143,000	144,000	157,000
New Mexico	59,000	60,000	61,000
Ohio	27,000	N/A(1)	—
Utah	61,000	59,000	55,000
Washington	288,000	285,000	276,000
Total	918,000	893,000	803,000

(1) Enrollment in our Ohio HMO at December 31, 2005 was less than 250 members.

The following table details member months (defined as the aggregation of each month's membership for the period) by state for the periods indicated:

	Three months ended March 31,		% of Increase (Decrease)
	2006	2005	
California	947,000	753,000	25.8%
Indiana	79,000	—	—
Michigan	431,000	471,000	(8.5)%
New Mexico	178,000	187,000	(4.8)%
Ohio	48,000	—	—
Utah	181,000	159,000	13.8%
Washington	868,000	823,000	5.5%
Total	2,732,000	2,393,000	14.2%

	Three months ended		
	March 31, 2006	December 31, 2005	% of Increase (Decrease)
California	947,000	971,000	(2.5)%
Indiana	79,000	70,000	12.9%
Michigan	431,000	436,000	(1.1)%
New Mexico	178,000	181,000	(1.7)%
Ohio	48,000	N/A(1)	—
Utah	181,000	176,000	2.8%
Washington	868,000	862,000	0.7%
Total	2,732,000	2,696,000	1.3%

(1) Enrollment in our Ohio HMO at December 31, 2005 was less than 250 members.

Our operating expenses include expenses related to the provision of medical care services and salary, general and administrative, or SG&A, costs. Our results of operations depend on our ability to effectively manage expenses related to health care services and accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically related administrative costs. Direct medical expenses include payments to physicians, hospitals and providers of ancillary medical services, such as pharmacy, laboratory and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services and compliance. Some of our primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while others are paid on a fee-for-service basis. Specialists and hospitals are paid for the most part on a fee-for-service basis. For the three months ended March 31, 2006, approximately 85.0% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis. Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic-related groups and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. We estimate our IBNR monthly based on a number of factors, including prior claims experience, inpatient hospital utilization data and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership and medical cost trends. These estimates are adjusted monthly as more information becomes available. We employ our own actuary and engage the service of independent actuaries as needed. We believe that our process for estimating IBNR is adequate, but all estimates are subject to uncertainties and our actual medical care costs have in the past exceeded such estimates. Our estimates of IBNR may be inadequate in the future, which would

negatively affect our results of operations. Additionally, our inability to accurately estimate IBNR may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results of operations.

SG&A costs are largely comprised of wage and benefit costs for employees and other administrative expenses. Some SG&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally-provided functions include marketing (to the extent permitted by law and regulation), plan administration and provider relations. Included in SG&A expenses are premium taxes for our California HMO (beginning July 1, 2005), Michigan HMO, New Mexico HMO, Ohio HMO and Washington HMO.

Results of Operations

The following table sets forth selected operating ratios. All ratios with the exception of the medical care ratio are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Three Months Ended March 31,	
	2006	2005
Premium revenue	99.1%	99.5%
Investment income	0.9%	0.5%
Total revenue	100.0%	100.0%
Medical care ratio	85.3%	84.9%
Salary, general and administrative expenses	11.3%	8.5%
Operating income	3.1%	6.1%
Net income	1.9%	3.7%

Three Months Ended March 31, 2006 Compared to Three Months Ended March 31, 2005

Net Income

Net income for the quarter ended March 31, 2006 was $8.6 million, or $0.31 per diluted share, compared with net income of $14.8 million, or $0.53 per diluted share, for the quarter ended March 31, 2005. The decrease in net income was primarily the result of an increase in medical care costs as a percentage of premium revenue (the medical care ratio) and an increase in salary, general and administrative expense as a percentage of total operating revenue (the administrative expense ratio).

Premium Revenue

Premium revenue for the first quarter of 2006 was $449.3 million, representing an increase of $57.1 million, or 14.6%, over 2005 premium revenue of $392.2 million. Membership growth resulting from acquisitions in California and from start-up operations in Indiana and Ohio was the primary driver of the increase in premium revenue.

Investment Income

Investment income increased by $2.3 million, or 131.3%, in the first quarter of 2006 as compared with 2005 as a result of higher invested balances and higher rates of return.

Medical Care Costs

Medical care costs as a percentage of premium revenue (the medical care ratio) increased to 85.3% in the first quarter of 2006 from 84.9% in the first quarter of 2005.

Medical care costs increased in absolute terms to $383.2 million in the first quarter of 2006 from $333.1 million in the first quarter of 2005. Hospital and specialty services and medical services costs increased as a percentage of premium

revenue in the first quarter of 2006 when compared to the first quarter of 2005. Pharmacy costs decreased as a percentage of premium revenue, principally due to benefit changes in New Mexico effective July, 2005 and increased pharmacy rebates in Washington.

Sequentially, the medical care ratio increased to 85.3% in the first quarter of 2006 from 84.7% in the fourth quarter of 2005. We believe that the increase in the medical care ratio between the fourth quarter of 2005 and the first quarter of 2006 was primarily the result of normal seasonality in health care utilization and costs. We further believe that certain medical cost control initiatives undertaken since the second quarter of 2005 have begun to have a positive impact upon our medical care ratio. In particular, we believe that the following actions have helped to control medical costs in the first quarter of 2006:

- Utilization of more cost-effective hospitals where such facilities are available;
- Enhanced monitoring of utilization at hospitals where more cost-effective alternatives are not available;
- Increased investment in medical and utilization management resources;
- Implementation of risk sharing arrangements with state payors; and
- Increased oversight of the claims payment process.

Salary, General and Administrative Expenses

Salary, general and administrative expenses were $51.2 million for the first quarter of 2006, representing 11.3% of total revenue, as compared with $33.5 million, or 8.5% of total revenue, for the first quarter of 2005.

Core G&A (defined as SG&A expenses less premium taxes) increased to 8.5% of total revenue in the first quarter of 2006 as compared with 5.9% in the first quarter of 2005. Excluding advertising costs, stock compensation costs (principally the expensing of employee stock options), state insurance assessments and administrative costs of our Texas start-up, core G&A was 7.4% of total revenue for the first quarter of 2006 compared to 5.5% of total revenue for the first quarter of 2005. Our adoption of SFAS No. 123R, Share-Based Payment, effective January 1, 2006, reduced earnings per diluted share by approximately $0.02 in the first quarter of 2006.

The remaining increase in core G&A was primarily due to investments in infrastructure to support our medical cost and quality initiatives and the administrative expenses associated with the development of Medicare Advantage Special Needs Plans.

Interest expense

Interest expense increased to $0.4 million in the first quarter of 2006 from $0.3 million for the same period in 2005 due to increased credit facility fees and expenses.

Depreciation and Amortization

Depreciation and amortization expense increased to $4.8 million for the three month period ended March 31, 2006 from $3.2 million for the same period in 2005. Increased amortization expense due to our acquisitions in California (which closed on June 1, 2005) contributed $0.6 million in additional amortization. Depreciation increased as a result of investment in infrastructure, principally at our corporate offices.

Income Taxes

Income taxes were recognized in the first quarter of 2006 based upon an effective tax rate of 37.5% as compared with an effective tax rate of 38.0% in the first quarter of 2005. We believe that the most significant factor affecting our effective tax rate is the proportion of consolidated income earned by subsidiaries operating in states that impose premium taxes rather than income taxes.

Liquidity and Capital Resources

We generate cash from premium revenue, services provided on a fee-for-service basis at our clinics and investment income. Our primary uses of cash include the payment of expenses related to medical care services and SG&A expenses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. At March 31, 2006, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. At March 31, 2006, our investments (all of which are classified as current assets) consisted solely of investment grade debt securities. Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Two professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yield for the three months ended March 31, 2006 and 2005 was approximately 4.4% and 2.2%, respectively.

The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities.

Net cash provided by operating activities was $41.0 million for the three months ended March 31, 2006 and $2.4 million for the three months ended March 31, 2005. Although net income was substantially higher in 2005 than in 2006, more cash was provided by operating activities in 2006 than in 2005 due to the following factors:

- Changes in medical claims liabilities (a source of $18.2 million in 2006 compared to a use of $4.7 million in 2005);
- Changes in accounts receivable balances (a use of $3.4 million in 2006 compared to a use of $8.7 million in 2005);
- Increases in deferred revenue (a source of $5.4 million in the three months ended March 31, 2006);
- Changes in taxes payable (a source of $6.6 million in 2006 compared to a use of $1.4 million in 2005);
- Increases in non-cash expenses ($1.1 million higher in 2006 than in 2005); and
- Aggregate changes in other miscellaneous working capital accounts (a use of $0.7 million in 2006, compared to a use of $2.7 million in 2005).

These factors were offset in part by the decrease in net income of $6.2 million for 2006 compared to the same period of 2005.

At March 31, 2006, we had working capital of $201.5 million as compared to $189.2 million at December 31, 2005. At March 31, 2006 and December 31, 2005, cash and cash equivalents were $288.3 million and $249.2 million, respectively. At March 31, 2006 and December 31, 2005, investments (all classified as current assets) were $101.7 million and $103.4 million, respectively.

At March 31, 2006, no amounts were drawn on our $180.0 million credit facility.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our seven HMO subsidiaries operating in California, Indiana, Michigan, New Mexico, Ohio, Utah and Washington. The HMOs are subject to state laws that, among other things, may require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment and amount of dividends and other distributions that may be paid to their stockholders.

The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary from state to state, have been adopted in Indiana, Michigan, Ohio, Utah and Washington. While New Mexico has not formally adopted the RBC rules, that state holds our New Mexico HMO to those rules. California has not adopted RBC rules and has not given notice of any intention to do so. The RBC rules, if adopted by California, may increase the minimum capital required by that state.

At March 31, 2006, our HMOs had aggregate statutory capital and surplus of approximately $171.8 million, compared with the required minimum aggregate statutory capital and surplus of approximately $118.3 million. All of our HMOs were in compliance with the minimum capital requirements at March 31, 2006. We have the ability and commitment to provide additional working capital to each of our HMOs when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements at least through 2006. We also believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements and capital expenditures for at least the next 12 months.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2005, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations and requires the application of significant judgment by our management and, as a result, is subject to an inherent degree of uncertainty.

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us (IBNR). We, together with our in-house actuaries, estimate medical claims liabilities using actuarial methods based upon historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the period known. We also record reserves for estimated referral claims related to medical groups under contract with us that are financially troubled or insolvent and that may not be able to honor their obligations for the payment of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses are not expected to be significant. In applying this policy, we use judgment to determine the appropriate assumptions for determining the required estimates. While we believe our current estimates are adequate, we have in the past been required to make a significant adjustment to these estimates and it is possible that future events could require us to make significant adjustments or revisions to these estimates. In assessing the adequacy of accruals for medical claims liabilities, we consider our historical experience, the terms of existing contracts, our knowledge of trends in the industry, information provided by our providers and information available from other sources as appropriate. The most significant estimates involved in determining our claims liability concern the determination of claims payment completion factors and trended per member per month cost estimates.

For the five months of service prior to the reporting date and earlier, we estimate our outstanding claims liability based upon actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date based on historical payment patterns. The following table reflects the change in our estimate of claims liability

as of March 31, 2006 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding March 31, 2006 by the percentages indicated. A reduction in the completion factor results in an increase in medical liabilities. Our Utah HMO is excluded from these calculations, as the majority of its business is conducted under a cost reimbursement contract. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ 19,023
(2)%	12,682
(1)%	6,341
1%	(6,341)
2%	(12,682)
3%	(19,023)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim. For these months of service, we estimate our claims liability based upon trended per member per month (PMPM) cost estimates. These estimates reflect recent trends in payments and expense, utilization patterns, authorized services and other relevant factors. The following table reflects the change in our estimate of claims liability as of March 31, 2006 that would

have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical liabilities. Our Utah HMO is excluded from these calculations, as the majority of its business is conducted under a cost reimbursement contract. Dollar amounts are in thousands.

Increase (Decrease) in Trended Per Member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ (9,672)
(2)%	(6,448)
(1)%	(3,224)
1%	3,224
2%	6,448
3%	9,672

Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNR at March 31, 2006, net income for the three months ended March 31, 2006 would increase or decrease by approximately $4.0 million, or $0.14 per diluted share, net of tax. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNR at March 31, 2006, net income for the three months ended March 31, 2006 would increase or decrease by approximately $2.0 million, or $0.07 per diluted share, net of tax.

The following table shows the components of the change in medical claims and benefits payable for the three months ended March 31, 2006 and 2005. Dollar amounts are in thousands.

	Three months ended March 31,	
	2006	2005
Balances at beginning of period	$ 217,354	$ 160,210
Components of medical care costs related to:		
Current year	407,847	343,065
Prior years	(24,600)	(9,951)
Total medical care costs	383,247	333,114
Payments for medical care costs related to:		
Current year	218,890	212,959
Prior years	146,132	124,800
Total paid	365,022	337,759
Balances at end of period	$ 235,579	$ 155,565

Our claims reserving methodology includes an allowance for adverse claims development at each reporting date based on our historical experience, and other factors considered by management including, but not limited to, variation in claims payment patterns, changes in utilization and cost trends, known outbreaks of disease, and large claims. Our reserving methodology has been consistently applied across all periods presented. Accordingly, any benefit recognized in medical care costs resulting from favorable development of an estimated liability at the start of the period may be offset by the addition of an allowance for adverse claims development when estimating the liability at the end of the period.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce

laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

Concentrations of Credit Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables and restricted investments. We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. Two professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit and treasury securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of March 31, 2006, we had cash and cash equivalents of $288.3 million, investments of $101.7 million and restricted investments of $18.2 million. Cash equivalents consist of highly liquid securities with original maturities of up to three months. At March 31, 2006, our investments (all of which are classified as current assets) consisted solely of investment grade debt securities. Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. The restricted investments consist of interest-bearing deposits required by the respective states in which we operate. These investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are maintained at fair market value on the balance sheet. Declines in interest rates over time will reduce our investment income.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13(a)-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended March 31, 2006 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II – OTHER INFORMATION

Item 1. Legal Proceedings

Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired Company stock between November 3, 2004 and July 20, 2005. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On March 13, 2006, the lead plaintiff filed its consolidated complaint. The consolidated complaint purports to allege claims against Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White for alleged violations of the Securities Exchange Act of 1934 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On May 1, 2006, the Company filed a motion to dismiss the consolidated complaint for failure to state a claim upon which relief can be granted. The Class Action is in the early stages, and no prediction can be made as to the outcome.

On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of Molina Healthcare, Inc against certain current and former officers and directors for breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402 arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

Arbitration with Tenet Hospital. In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4.5 million involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8.0 million. The parties have agreed to present their arguments in phases. The first phase of the arbitration, comprising approximately $3.0 million of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1.7 million by the arbitrator. We paid the award in January 2006. This amount is in addition to approximately $0.33 million we paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. The parties are currently conducting the second phase of the arbitration. We believe that the California HMO has meritorious defenses to Tenet's claims and we intend to vigorously defend this matter. Nevertheless, at December 31, 2005, we had recorded additional expense beyond the amount of $2.033 million discussed above in connection with this matter. We do not believe that the ultimate resolution of this matter will materially affect our consolidated financial position, results of operations, or cash flows beyond the impact of the liability recorded in connection with this matter.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named HMOs participating in the New Mexico Medicaid program as defendants, including the predecessor of the New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery has recently commenced. It is not currently possible to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons,

Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6,000 in order indemnify our New Mexico HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, $4,443 remains in the indemnification escrow fund.

Antelope Valley. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO. To date, our California HMO has not been served with the complaint. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2.0 million, plus interest and attorney fees. The Antelope Valley matter is in the early stages, and no prediction can be made as to the outcome.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. Risk Factors

In addition to the other information set forth in this report, you should carefully consider the factors discussed in Part I, "Item 1A. Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2005, which could materially affect our business, financial condition, or future results. The risks described in our Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition, and/or operating results.

Item 4: ***Submission of Matters to a Vote of Security Holders***

At our 2006 Annual Meeting of Stockholders held on May 3, 2006, our stockholders elected as Class I directors Dr. Frank E. Murray and Mr. John P. Szabo, Jr. 25,847,644 shares were voted for Dr. Murray, with 80,651 shares withheld. 25,768,794 shares were voted for Mr. Szabo, with 159,501 shares withheld. Their terms as Class I directors shall continue until the 2009 Annual Meeting.

The stockholders also voted to amend the Company's 2002 Equity Incentive Plan to allow the Company to use the entire pool of shares reserved under the plan for the issuance of not only stock options but also restricted stock and stock bonus awards. 19,535,124 shares were voted for the proposed amendment of the 2002 Equity Incentive Plan, with 4,119,665 shares voted against, 5,044 shares voted as abstaining, and 2,268,462 shares not voted.

Item 6. Exhibits

Exhibit No.	Title
10.1	Contract between Molina Healthcare of Utah and Utah Department of Health extending contract term through June 30, 2006.
10.2	Contract between Molina Healthcare of Washington and Washington Department of Social and Health Services extending Healthy Options and State Children's Health Insurance Program contract term through December 31, 2006.
10.3	Contract between Molina Healthcare of Washington and Washington Department of Social and Health Services extending Basic Health and Basic Health Plus Program contract term through December 31, 2006.
10.4	Contract between Molina Healthcare of California Partner Plan, Inc. and California Department of Health Services extending Inland Empire contract term through March 31, 2007.
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

Dated: May 9, 2006

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,

Chief Executive Officer and President
(Principal Executive Officer)

Dated: May 9, 2006

/s/ JOHN C. MOLINA, J.D.

John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

UTAH DEPARTMENT OF HEALTH
Box 143104
288 North 1460 West, Salt Lake City, Utah 84114- 3104
CONTRACT

H0535503
Department Log Number — State Contract Number

1. CONTRACT NAME:
The name of this Contract is Health Plan - Molina.

2. CONTRACTING PARTIES:
This Contract is between the Utah Department of Health (DEPARTMENT), and Molina Healthcare of Utah (CONTRACTOR).

3. CONTRACT PERIOD:
The service period of this Contract will be January 1, 2006 through June 30, 2006, unless terminated or extended by agreement in accordance with the terms and conditions of this Contract. This Contract may be extended annually 1 times, at the option of the DEPARTMENT, by means of an amendment to this Contract. Such extension must be in writing.

4. CONTRACT AMOUNT:
The CONTRACTOR will be paid up to a maximum amount of $90,000,000.00 in accordance with the provisions in this Contract. This Contract is funded with 70.76% Federal funds and with 29.24% State funds. The CFDA # is 93.778 and relates to the federal funds provided.

5. CONTRACT INQUIRIES:
Inquiries regarding this Contract shall be directed to the following individuals:

CONTRACTOR		DEPARTMENT	
Contact Person:	Brian Monsen	Program:	Managed Health Care
Business Address:	7050 Union Park Ctr #200 Salt Lake City, UT 84074	Contact Person:	Julie Olson
		Phone Number:	(801) 538-6505
Phone Number:	(801) 587-6443		

6. REFERENCE TO ATTACHMENTS INCLUDED AS PART OF THIS CONTRACT:

Attachment A:	Utah Department of Health General Provisions
Attachment B:	Special Provisions
Attachment C:	Covered Services
Attachment D:	Utah's Quality Assessment and Performance Improvement Plan
Attachment E:	Medicaid Enrollment (Table 1), Cost Date (Table 2), Utilization Data (Table 3), Medicaid Malpractice Information (Table 4)
Attachment F:	Payment Methodology

7. PROVISIONS INCORPORATED INTO THIS CONTRACT BY REFERENCE, BUT NOT ATTACHED HERETO:

A. All other governmental laws, rules, regulations, or actions applicable to services provided herein.

B. If the CONTRACTOR has provided the DEPARTMENT with Assurances, then the DEPARTMENT is entering into this agreement based upon the Assurances provided by the CONTRACTOR and the Assurances are incorporated by reference.

8. If the CONTRACTOR is not a local public procurement unit as defined by the Utah Procurement Code (UCA § 63-56-5), this Contract must be signed by a representative of the State Division of Finance and the State Division of Purchasing to bind the State and the DEPARTMENT to this Contract.

9. This Contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supercede all prior negotiations, representations, or agreements, either written or oral between the parties relating to the subject matter of this Contract.

IN WITNESS WHEREOF, the parties sign this Contract.

CONTRACTOR: Molina Healthcare of Utah

By: /s/ G. Kirk Olsen
Signature of Authorized Individual — Date

Print Name: G. Kirk Olsen

Title: Chief Executive Officer

33-0617992
Federal Tax Identification Number

UTAH DEPARTMENT OF HEALTH

By: /s/ Shari A. Watkins
Shari A. Watkins, C.P.A. — Date
Director
Office of Fiscal Operations

State Finance: Date

State Purchasing: Date

ATTACHMENT "A"

UTAH DEPARTMENT OF HEALTH

General Provisions

I. CONTRACT DEFINITIONS	**1**
II. AUTHORITY	**1**
III. MISCELLANEOUS PROVISIONS	**2**
IV. UTAH INDOOR CLEAN AIR ACT	**3**
V. RELATED PARTIES & CONFLICTS OF INTEREST	**4**
VI. OTHER CONTRACTS	**4**
VII. SUBCONTRACTS & ASSIGNMENTS	**4**
VIII. FURTHER WARRANTY	**4**
IX. INFORMATION OWNERSHIP	**4**
X. SOFTWARE OWNERSHIP	**4**
XI. INFORMATION PRACTICES	**5**
XII. INDEMNIFICATION	**5**
XIII. SUBMISSION OF REPORTS	**6**
XIV. PAYMENT	**6**
XV. RECORD KEEPING, AUDITS, & INSPECTIONS	**6**
XVI. CONTRACT ADMINISTRATION REQUIREMENTS	**7**
XVII. DEFAULT, TERMINATION, & PAYMENT ADJUSTMENT	**9**
XVIII. FEDERAL REQUIREMENTS	**10**

ATTACHMENT "A"

UTAH DEPARTMENT OF HEALTH GENERAL PROVISIONS

I. CONTRACT DEFINITIONS

The following definitions apply in these general provisions:

"**Assign**" or "**Assignment**" means the transfer of all rights and delegation of all duties in the contract to another person.

"**Business**" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or any other private legal entity.

"**This Contract**" means this agreement between the Department and the Contractor, including both the General Provisions and the Special Provisions.

"**The Contractor**" means the person who delivers the services or goods described in this Contract, other than the state or the Department.

"**The Department**" means the Utah Department of Health.

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

"**Equipment**" means capital equipment which costs at least $1,000 and has a useful life of one year or more unless a different definition or amount is set forth in the Special Provisions or specific Department Program policy as described in writing to Contractor.

"**Federal law**" means the constitution, orders, case law, statutes, rules, and regulations of the federal government.

"**General provisions**" means those provisions of this Contract which are set forth under the heading "General Provisions."

"**Governmental entity**" means a federal, state, local, or federally-recognized Indian tribal government, or any subdivision thereof.

"**Individual**" means a living human being.

"**Local health department**" means a local health department as defined in § 26A-1-102, Utah Code Annotated, 1953 as amended (UCA.).

"**Non-governmental entity**" means privately held non-profit or for profit organization not classified as a "Governmental entity."

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

"**Recipient**" means an individual who is eligible for services provided by the Department or by an authorized Contractor of the Department under the terms of this Contract.

"**Services**" means the furnishing of labor, time, or effort by a Contractor, not involving the delivery of a specific end product other than reports which are merely incidental to the required performance.

"**Special provisions**" means those provisions of this Contract which are in addition to the General Provisions and which more fully describe the goods or services covered by this Contract.

"**State**" means the State of Utah.

"**State law**" means the constitution, orders, case law, statutes, and rules, of the state.

"**Subcontract**" means any signed agreement between the Contractor and a third party to provide goods or services for which the Contractor is obligated, except purchase orders for standard commercial equipment, products, or services.

"**Subcontractor**" means the person who performs the services or delivers the goods described in a subcontract.

II. AUTHORITY

1. The Department's authority to enter into this Contract is derived from Chapter 56, Title 63, UCA; Titles 26 and 26A, UCA; and from related statutes.

2. The Contractor represents that it has the institutional, managerial, and financial capability to ensure proper planning, management, and completion of the project or services described in this Contract.

III. MISCELLANEOUS PROVISIONS

1. For reference clarity, as used in these General Provisions: "ARTICLE" refers to a major topic designated by capitalized roman numerals; "SECTION" refers to the next lower numbered heading designated by arabic numerals, and "SUBSECTIONS" refers to the next two lower headings designated by lower case letters and lower case roman numerals.

2. If the General Provisions and the special provisions of this Contract conflict, the special provisions govern.

3. These provisions distinguish between two Contractor types: Governmental and Non-governmental. Unspecified text applies to both types. Type-specific statements appear in bold print (*e.g.*, **Non-governmental entities only**).

4. Once signed by the Director and the State Division of Finance, when applicable, and the State Division of Purchasing, when applicable, this Contract becomes effective on the date specified in this Contract. Changes made to the unsigned Contract document shall be initialed by both persons signing this Contract on page one. Changes made to this Contract after the signatures are made on page one may only be made by a separate written amendment signed by persons authorized to amend this Contract.

5. Neither party may enlarge, modify, or reduce the terms, scope of work, or dollar amount in this Contract, except by written amendment as provided in section 4.

6. This Contract and the contracts that incorporate its provisions contain the entire agreement between the Department and the Contractor. Any statements, promises, or inducements made by either party or the agent of either party which are not contained in the written Contract or other contracts are not valid or binding.

7. The Contractor shall comply with all applicable laws regarding federal and state taxes, unemployment insurance, disability insurance, and workers' compensation.

8. The Contractor is an independent Contractor, having no authorization, express or implied, to bind the Department to any agreement, settlement, liability, or understanding whatsoever, and agrees not to perform any acts as agent for the Department unless expressly set forth herein. Compensation stated herein shall be the total amount payable to the Contractor by the Department. The Contractor shall be responsible for the payment of all income tax and social security amounts due as a result of payments received from the Department for these contract services.

9. The Contractor shall maintain all licenses, permits, and authority required to accomplish its obligations under this Contract.

10. The Contractor shall obtain prior written Department approval before purchasing any equipment with contract funds.

11. Notice shall be in writing, directed to the contact person on page one of this Contract, and delivered by certified mail or by hand to the other party's most currently known address. The notice shall be effective when placed in the U.S. mail or hand-delivered.

12. The Department and the Contractor shall attempt to resolve contract disputes through available administrative remedies prior to initiating any court action.

13. This Contract shall be construed and governed by the laws of the State of Utah. The Contractor submits to the jurisdiction of the courts of the State of Utah for any dispute arising out of this Contract or the breach thereof. The proper venue of any legal action arising under this contract shall be in Salt Lake City, Utah.

14. Any court ruling or other binding legal declaration which declares that any provision of this Contract is illegal or void, shall not affect the legality and enforceability of any other provision of this Contract, unless the provisions are mutually dependent.

15. The Contractor agrees to maintain the confidentiality of records that it holds as agent for the Department as required by the Government Records Access and Management Act, Title 63, Chapter 2, UCA and the confidentiality of records requirements of Title 26, UCA.

16. The Contractor agrees to abide by the State of Utah's executive order, dated March 17,1993, which prohibits sexual harassment in the workplace.

17. The waiver by either party of any provision, term, covenant or condition of this Contract shall not be deemed to be a waiver of any other provision, covenant or condition of this Contract nor any subsequent breach of the same or any other provision, term, covenant or condition of this Contract.

18. The Contractor agrees to warrant and assume responsibility for each hardware, firmware, and/or software product (hereafter called the product) that it licenses, or sells, to the Department under this Contract. The Contractor

acknowledges that the Uniform Commercial Code applies to this Contract. In general, the Contractor warrants that:

(a) the product will do what the salesperson said it would do, (b) the product will live up to all specific claims that the manufacturer makes in their advertisements, (c) the product will be suitable for the ordinary purposes for which such product is used, (d) the product will be suitable for any *special purposes* that the Department has relied on the Contractor's skill or judgement to consider when it advised the Department about the product, (e) the product has been properly designed and manufactured, and (f) the product is free of significant defects or unusual problems about which the Department has not been warned.

19. The State of Utah's sales and use tax exemption number is E33399. The tangible personal property or services being purchased are being paid for from State funds and used in the exercise of that entity's essential functions. If the items purchased are construction materials, they will be converted into real property by employees of this government entity, unless otherwise stated in the contract.

20. The Contractor agrees that the Contract will be a public document, and may be available for distribution. Contractor gives the Department express permission to make copies of the Contract and/or of the response to the solicitation in accordance with State of Utah Government Records Access and Management Act. The permission to make copies as noted will take precedence over any statements of confidentiality, proprietary information, copyright information, or similar notation.

21. This Contract may be amended, modified, or supplemented only by written amendment to the Contract, executed by the parties hereto, and attached to the original, signed copy of the Contract..

22. Unless otherwise specified in this Contract, all deliveries will be F.O.B. destination with all transportation and handling charges paid by the Contractor. Responsibility and liability for loss or damage will remain with Contractor until final inspection and acceptance, when responsibility will pass to the Department, except as to latent defects, fraud and Contractor's warranty obligations.

23. All orders will be shipped promptly in accordance with the delivery schedule. The Contractor will promptly submit invoices (within 30 days of shipment or delivery of services) to the Department. The State contract number and/or the agency purchase order number shall be listed on all invoices, freight tickets, and correspondence relating to the Contract order. The prices paid by the Department will be those prices listed in the Contract. The Department has the right to adjust or return any invoice reflecting incorrect pricing.

24. The Contractor will release, indemnify, and hold the State, its officers, agents, and employees harmless from liability of any kind or nature, including the Contractor's use of any copyrighted or un-copyrighted composition, secret process, patented or un-patented invention, article, or appliance furnished or used in the performance of this Contract.

25. Neither party to this Contract will be held responsible for delay or default caused by fire, riot, acts of God, and/or war which is beyond that party's reasonable control. The Department may terminate this Contract after determining that such delay or default will reasonably prevent successful performance of the Contract.

26. The Contractor understands that a person who is interested in any way in the sale of any supplies, services, construction, or insurance to the State of Utah is violating the law if the person gives or offers to give any compensation, gratuity, contribution, loan, or reward, or any promise thereof to any person acting as a procurement officer on behalf of the State, or who in any official capacity participates in the procurement of such supplies, services, construction, or insurance, whether it is given for their own use or for the use or benefit of any other person or organization (63-56-73, Utah Code Annotated, 1953 as amended).

27. Contractor Terms and Conditions that apply must be in writing and attached to the Contract. No other Terms and Conditions will apply to this Contract, including terms listed or referenced on a Contractor's website, terms listed in a Contractor quotation/sales order, etc. In the event of any conflict in the contract terms and conditions, the order of precedence shall be: a. Department General Provisions; b. Department Special Provisions; c. Contractor Terms and Conditions.

IV. UTAH INDOOR CLEAN AIR ACT

The Contractor, for all personnel operating within the State of Utah, shall comply with the Utah Indoor Clean Air Act, Title 26, Chapter 38, UCA, which prohibits smoking in public places.

V. RELATED PARTIES & CONFLICTS OF INTEREST

1. The Contractor may not pay related parties for goods, services, facilities, leases, salaries, wages, professional fees, or the like for contract expenses without the prior written consent of the Department. The Department may consider the payments to the related parties as disallowed expenditures and accordingly adjust the Department's payment to the Contractor for all related party payments made without the Department's consent. As used in this section, "related parties" means any person related to the Contractor by blood, marriage, partnership, common directors or officers, or 10% or greater direct or indirect ownership in a common entity.

2. The Contractor shall comply with the Public Officers' and Employees' Ethics Act, § 67-16-10, UCA, which prohibits actions that may create or that are actual or potential conflicts of interest. It also provides that "no person shall induce or seek to induce any public officer or public employee to violate any of the provisions of this act." The Contractor represents that none of its officers or employees are officers or employees of the State of Utah, unless disclosure has been made in accordance with § 67-16-8, UCA.

VI. OTHER CONTRACTS

1. The Department may perform additional work related to this Contract or award other contracts for such work. The Contractor shall cooperate fully with other contractors, public officers, and public employees in scheduling and coordinating contract work. The Contractor shall give other contractors reasonable opportunity to execute their work and shall not interfere with the scheduled work of other contractors, public officers, and public employees.

2. The Department shall not unreasonably interfere with the Contractor's performance of its obligations under this Contract.

VII. SUBCONTRACTS & ASSIGNMENTS

The Contractor shall not assign, sell, transfer, subcontract, or sublet rights or delegate responsibilities under this Agreement, in whole or part, without the prior written consent of the Department. The Department agrees that the Contractor may partially subcontract services, provided that the Contractor retains ultimate responsibility for performance of all terms, conditions and provisions of this Agreement. When subcontracting, the Contractor agrees to use written subcontracts that conform with Federal and State laws. The Contractor shall request Department approval for any assignment at least 20 days prior to its effective date.

VIII. FURTHER WARRANTY

The Contractor warrants that (a) all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with generally recognized standards; and (b) all goods or products furnished pursuant to this Contract shall be free from defects and shall conform to contract requirements. For any item that the Department determines does not conform with the warranty, the Department may arrange to have the item repaired or replaced, either by the Contractor or by a third party at the Department's option, at the Contractor's expense.

IX. INFORMATION OWNERSHIP

Except for confidential medical records held by direct care providers, the Department shall own exclusive title to all information gathered, reports developed, and conclusions reached in performance of this Contract. The Contractor may not use, except in meeting its obligations under this Contract, information gathered, reports developed, or conclusions reached in performance of this Contract without the express written consent of the Department.

X. SOFTWARE OWNERSHIP

1. If the Contractor develops or pays to have developed computer software exclusively with funds or proceeds from this Contract to perform its obligations under this Contract, or to perform computerized tasks that it was not previously performing to meet its obligations under this Contract, the computer software shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor

has completed its work under this Contract.

2. If the Contractor develops or pays to have developed computer software which is an addition to existing software owned by or licensed exclusively with funds or proceeds from this Contract, or to modify software to perform computerized tasks in a manner different than previously performed, to meet its obligations under this Contract, the addition shall be exclusively owned by or licensed to the Department. In the case of software owned by the Department, the Department grants to the Contractor a nontransferable, nonexclusive license to use the software in the performance of this Contract. In the case of software licensed to the Department, the Department grants to the Contractor permission to use the software in the performance of this Contract. This license or permission, as the case may be, terminates when the Contractor has completed its work under this Contract.

3. If the Contractor uses computer software licensed to it which it does not modify or program to handle the specific tasks required by this Contract, then to the extent allowed by the license agreement between the Contractor and the owner of the software, the Contractor grants to the Department a continuing nonexclusive license to use the software, either by the Department or by a different Contractor, to perform work substantially identical to the work performed by the Contractor under this Contract. If the Contractor cannot grant the license as required by this section, then the Contractor shall reveal the input screens,

report formats, data structures, linkages, and relations used in performing its obligations under this Contract in such a manner to allow the Department or another Contractor to continue the work performed by the Contractor under this Contract.

4. The Contractor shall deliver to the Department a copy of the software or information required by this Article within 90 days after the commencement of this Contract and thereafter immediately upon making a modification to any of the software which is the subject of this Contract.

XI. INFORMATION PRACTICES

1. **(Governmental entities only)** The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor assures that any information about an individual that it receives or requests from the Department pursuant to this Contract is necessary to the performance of its duties and functions and that the information will be used only for the purposes set forth in this Contract. The Department shall inform the Contractor of any non-public designation of any information it provides to the Contractor.

2. **(Non-governmental entities only)** The Contractor shall establish, maintain, and practice information procedures and controls that comply with Federal and State law. The Contractor may not release any information regarding any person from any information provided by the Department, unless the Department first consents in writing to the release.

XII. INDEMNIFICATION

1. **(Governmental entities only)** It is mutually agreed that each party assumes liability for the negligent or wrongful acts committed by its own agents, officials, or employees, regardless of the source of funding for this Contract. Neither party waives any rights or defenses otherwise available under the Governmental Immunity Act.

2. **(Non-governmental entities only)** To the extent authorized by law, the Contractor shall indemnify and hold harmless the Department and any of its agents, officers, and employees, from any claims, demands, suits, actions, proceedings, loss, injury, death, and damages of every kind and description, including any attorney's fees and litigation expenses, which may be brought, made against, or incurred by that party on account of loss or damage to any property, or for injuries to or death of any person, caused by, arising directly or indirectly out of, or contributed to in whole or in part, by reason of any alleged act, omission, professional error, fault, mistake, or negligence of the Contractor or its employees, agents, or representatives, or subcontractors or their employees, agents, or representatives, in connection with, incident to, or arising directly or indirectly out of this Contract, or arising out of workers' compensation claims, unemployment, or claims under similar such laws or obligations.

XIII. SUBMISSION OF REPORTS

If the Contractor is a Local Health Department, it shall submit monthly expenditure reports to the Department in a format approved by the Department. All other Contractors shall submit monthly summarized billing statements to the Department. Expenditure reports and billing statements must be submitted to the Department within 30 days following the last day of the month in which the expenditures were incurred or the services provided.

XIV. PAYMENT

1. If a recipient, a recipient's insurance, or any third-party is responsible to pay for services rendered pursuant to this Contract, the Contractor shall bill and collect for the goods or services provided to the recipient. The Department shall reimburse total actual expenditures, less amounts collected as required by this section.

2. Under no circumstances shall the Department authorize payment to the Contractor that exceeds the amount specified in this Contract without an amendment to the Contract.

3. The Department agrees to make every effort to pay for completed services, and payments are conditioned upon receipt of applicable, accurate, and completed reports prepared by the Contractor and delivered to the Department. The Department may delay or deny payment for final expenditure reports received more than 20 days after the Contractor has satisfied all Contract requirements.

4. In the case that funds are not appropriated or are reduced, the Department will reimburse Contractor for products delivered or services performed through the date of cancellation or reduction, and the Department will not be liable for any future commitments, penalties, or liquidated damages.

XV. RECORD KEEPING, AUDITS, & INSPECTIONS

1. The Contractor shall use an accrual or a modified accrual basis for reporting annual fiscal data, as required by Generally Accepted Accounting Principles (GAAP). Required monthly or quarterly reports may be reported using a cash basis.

2. The Contractor and any subcontractors shall maintain financial and operation records relating to contract services, requirements, collections, and expenditures in sufficient detail to document all contract fund transactions. The Contractor and any subcontractors shall maintain and make all records necessary and reasonable for a full and complete audit, inspection, and monitoring of services by state and federal auditors, and Department staff during normal business hours or by appointment, until all audits and reviews initiated by federal and state auditors are completed, or for a period of four years from the date of termination of this Contract, whichever is longer, or for any period required elsewhere in this Contract.

3. The Contractor shall retain all records which relate to disputes, litigations, claim settlements arising from contract performance, or cost/expense exceptions initiated by the Director, until all disputes, litigations, claims, or exceptions are resolved.

4. The Contractor shall comply with federal and state regulations concerning cost principles, audit requirements, and grant administration requirements, cited in Table 1. Unless specifically exempted in this Contract's special provisions, the Contractor must comply with applicable federal cost principles and grant administration requirements if state funds are received. The Contractor shall also provide the Department with a copy of all reports required by the State Legal Compliance Audit Guide (SLCAG) as defined in Chapter 2, Title 51, UCA. All federal and state principles and requirements cited in Table 1 are available for inspection at the Utah Department of Health during normal business hours. A Contractor who receives $100,000 or more in a year from all

federal or from all state sources may be subject to federal and state audit requirements. A Contractor who receives $500,000 for fiscal years ending after December 31, 2003 or more per year from federal sources may be subject to the federal single audit requirement. Counties, cities, towns, school districts, and all non-profit corporations that receive 50 percent or more of its funds from federal, state or local governmental entities are subject to the State of Utah Legal Compliance Audit Guide. Copies of required audit reports shall be sent to the Utah Department of Health, Bureau of Financial Audit, Box 144002, Salt Lake City, Utah 84114-4002.

Federal and State Principles and Requirements

Contractor	Cost Principles	Federal Audit Requirements	State Audit Requirements	Grant Admin. Requirements
State or Local Govt. & Indian Tribal Govts.	OMB Circular A-87	OMB Circular A-133	SLCAG	OMB Common Rule
Hospitals	45 CFR 74, App. E	OMB Circular A-133	SLCAG	OMB Common Rule or Circular A-110
College or University	OMB Circular A-21	OMB Circular A-133	SLCAG	OMB Circular A-110
Non-Profit Organization	OMB Circular A-122	OMB Circular A-133	SLCAG	OMB Circular A-110
For-Profit Organization	48 CFR 31	n/a	n/a	OMB Circular A-110

Documents	Web Address
OMB Circulars	http://www.whitehouse.gov/omb/circulars/index.html
OMB Common Rule	http://www.whitehouse.gov/omb/grants/attach.html
CFRs	http://www.access.gpo.gov/nara/cfr/cfr-table-search.html
SLCAG	http://www.sao.state.ut.us/resources/resources-lg.htm

Table 1

XVI. CONTRACT ADMINISTRATION REQUIREMENTS

The Contractor agrees to administer this Contract in compliance with either OMB Common Rule or OMB Circular A-110 depending upon the legal status of the of the Contractor as shown in Table 1. Financial management, procurement, and affirmative step requirements specify that:

1. the Contractor must have fiscal control and accounting procedures sufficient to:

   a. permit preparation of reports required by this Contract, and

   b. permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of applicable statutes.

2. the Contractor's financial management systems must meet the following standards:

   a. *financial reporting.* Accurate, current, and complete disclosure of the financial results of financially assisted activities must be made in accordance with the financial reporting requirements of this Contract.

   b. *accounting records.* The Contractor must maintain records which adequately identify the source and application of funds provided for federally financially-assisted activities. These records must contain information pertaining to the Contract's awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income.

   c. *internal control.* Effective control and accountability must be maintained for all Contract cash, real and personal property, and other assets. The Contractor must adequately safeguard all such property and must assure that it is used solely for authorized purposes.

   d. *budget control.* Actual expenditures or outlays must be compared with budgeted amounts for the Contract Financial information must be related to performance or productivity data, including the development of unit cost information whenever appropriate or specifically required in this Contract. If unit cost data are required, estimates based on available documentation will be accepted whenever possible.

3. Federal OMB cost principles, federal agency program regulations, and the terms of grant and subgrant, and contract agreements will be followed in determining the reasonableness, allowability, and allocability of costs.

   a. *source documentation.* Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract and subcontract award documents, etc.

   b. *cash management.* Procedures for minimizing the time elapsing between the transfer of funds from the U.S. Treasury and disbursement by the Department and the Contractor must be followed whenever advance payment procedures are used.

4. the Contractor shall use its own procurement procedures which reflect applicable State and local laws, rules, and regulations, provided that the procurements conform to applicable Federal law and the standards identified in this Contract.

a. The Contractor will maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of its contracts or purchase orders.

b. The Contractor will maintain a written code of standards of conduct governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Department or the Contractor shall participate in selection, or in the award or administration of a contract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

i. the employee, officer or agent,
ii. any member of his immediate family,
iii. his or her partner; or
iv. an organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Department's or the Contractor's officer, employees or agents will neither solicit nor accept gratuities, favors or anything of monetary value from contractors, potential contractors, or parties to subagreements. The Department and the Contractor may set minimum rules where the financial interest is not substantial or the gift is an unsolicited item of nominal intrinsic value. To the extent permitted by State or local law or regulations, such standards or conduct will provide for penalties, sanctions, or other disciplinary actions for violations of such standards by the Department's or the Contractor's officers, employees, or agents, or by subcontractors or their agents.

c. The Contractor's procedures will provide for a review of proposed procurements to avoid purchase of unnecessary or duplicative items. Consideration should be given to consolidating or breaking out procurements to obtain a more economical purchase. Where appropriate, an analysis will be made of lease versus purchase alternatives, and any other appropriate analysis to determine the most economical approach.

d. To foster greater economy and efficiency, the Contractor, if a governmental entity, is encouraged to enter into State and local intergovernmental agreements for procurement or use of common goods and services.

e. If allowed by law, the Contractor is encouraged to use Federal excess and surplus property in lieu of purchasing new equipment and property whenever such use is feasible and reduces project costs.

f. The Contractor may contract only with responsible contractors possessing the ability to perform successfully under the terms and conditions of a proposed procurement.

g. The Contractor shall maintain records sufficient to detail the significant history of a procurement. These records shall include, but are not necessarily limited to the following:

i. the rationale for the method of procurement,
ii. selection of contract type,
iii. contractor selection or rejection, and
iv. the basis for the contract price.

h. The Contractor may use time and material type contracts only:
i. after a determination that no other contract is suitable, and
ii. if the Contract includes a ceiling price that the Contractor exceeds at its own risk.

i. The Contractor alone will be responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements. These issues include, but are not limited to source evaluation, protests, disputes, and claims. These standards do not relieve the Contractor of any contractual responsibilities under its contracts.

j. The Contractor shall have protest procedures to handle and resolve disputes relating to its procurements and shall in all instances disclose information regarding the protest to the federal funding agency. A protestor must exhaust all administrative remedies with the Department and the Contractor before pursuing a protest with the federal funding agency.

5. the Contractor shall take all necessary affirmative steps to assure that minority firms, women's business enterprises, and labor surplus area firms are used when possible. Affirmative steps shall include:

a. placing qualified small and minority businesses and women's business enterprises on solicitation lists;

b. assuring that small and minority businesses, and women's business enterprises are solicited whenever they

are potential sources;

c. dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority business, and women's business enterprises;

d. establishing delivery schedules, where the requirement permits, which encourage participation by small and minority business, and women's business enterprises;

e. using the services and assistance of the Small Business Administration, and the Minority Business Development Agency of the Department of Commerce; and

f. requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in Article XVI, section 5, subsections a - e.

XVII. DEFAULT, TERMINATION, & PAYMENT ADJUSTMENT

1. Each party may terminate this Contract with cause. If the cause for termination is due to the default of a party, the non-defaulting party shall send a notice, which meets the notice requirements of this Contract, citing the default and giving notice to the defaulting party of its intent to terminate. The defaulting party may cure the default within fifteen days of the notice. If the default is not cured within the fifteen days, the party giving notice may terminate this Contract 45 days from the date of the initial notice of default or at a later date specified in the notice.

2. The Department may terminate this Contract without cause, in advance of the specified termination date, upon 30 days written notice.

3. The Department agrees to use its best efforts to obtain funding for multi-year contracts. If continued funding for this Contract is not appropriated or budgeted at any time throughout the multi-year contract period, the Department may terminate this Contract upon 30 days notice.

4. If funding to the Department is reduced due to an order by the Legislature or the Governor, or is required by federal or state law, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 days written notice. If the specific funding source for the subject matter of this Contract is reduced, the Department may terminate this Contract or proportionately reduce the services and goods due and the amount due from the Department upon 30 written notice being given to the Contractor.

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

6. If the Contractor terminates this Contract without cause, the Department may treat the Contractor’s action as a default under this Contract.

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

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

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

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

11. Any of the following events will constitute cause for the Department to declare Contractor in default of the Contract: a. Nonperformance of contractual requirements; b. A material breach of any term or condition of this contract. The Department will issue a written notice of default providing a ten (10) day period in which Contractor will have an opportunity to cure. Time allowed for cure will not diminish or eliminate Contractor’s liability for damages. If the default remains, after Contractor has been provided the opportunity to cure, the Department may do one or more of the following: c. Exercise any remedy provided by law; d. Terminate this Contract and any related Contracts or portions thereof; e. Impose liquidated damages, if liquidated damages are listed in the Contract; f. Suspend Contractor from receiving future solicitations.

XVIII. FEDERAL REQUIREMENTS

The Contractor shall comply with all applicable federal requirements. To the extent that the Department is able, the Department shall give further clarification of federal requirements upon the Contractor’s request. If the Contractor is receiving federal funds under this Contract, certain federal requirements apply. The Contractor agrees to comply with the federal requirements to the extent that they are applicable to the subject matter of this Contract and are required by the amount of federal funds involved in this Contract.

1. **Civil Rights Requirements:**

   a. The Civil Rights Act of 1964, Title VI, provides that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing this requirement is 45 CFR Part 80.

   b. The Civil Rights Act of 1964, Title VII, (P.L. 88-352 & 42 U.S.C. § 2000e) prohibits employers from discriminating against employees on the basis of race, color, religion, national origin, and sex. Title VII applies to employers of fifteen or more employees, and prohibits all discriminatory employment practices.

   c. The Rehabilitation Act of 1973, as amended, section 504, provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any

program or activity receiving federal financial assistance. The Health and Human Services regulation 45 CFR Part 84 implements this requirement.

d. The Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), prohibits unreasonable discrimination on the basis of age in any program or activity receiving federal financial assistance. The Health and Human Services regulation implementing the provisions of the Age Discrimination Act is 45 CFR Part 91.

e. The Education Amendments of 1972, Title IX, (20 U.S.C. §§ 1681-1683 and 1685-1686), section 901, provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving federal financial assistance. Health and Human Services regulation 45 CFR Part 86 implements this requirement.

f. Executive Order No. 11246, as amended by Executive Order 11375 relates to “Equal Employment Opportunity,” (all construction contracts and subcontracts in excess of $10,000)

g. Americans with Disabilities Act of 1990, (P.L.101-336), section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), prohibits discrimination on the basis of disability.

h. The Public Health Service Act, as amended, Title VII, section 704 and TITLE VIII, section 855, forbids the extension of federal support for health manpower and nurse training programs authorized under those titles to any entity that discriminates on the basis of sex in the admission of individuals to its training programs. Health and Human Services regulation implementing this requirement is 45 CFR Part 83.

i. The Public Health Service Act, as amended, section 526, provides that drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment because of their drug abuse or drug dependence, by any private or public general hospital that receives support in any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

j. The Public Health Service Act, as amended, section 522, provides that alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital that receives support in

any form from any federally funded program. This prohibition is extended to all outpatient facilities receiving or benefitting from federal financial assistance by 45 CFR Part 84.

2. **Confidentiality:** The Public Health Service Act, as amended, sections 301(d) and 543, require that certain records be kept confidential except under certain specified circumstances and for specified purposes. Confidential records include records of the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with the performance of any activity or program relating to drug abuse prevention, i.e., drug abuse education, training, treatment, or research, or alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research that is directly or indirectly assisted by the federal government. Public Health Service regulations 42 CFR Parts 2 and 2a implement these requirements.

3. **Lobbying Restrictions:** Lobbying restrictions as required by 31 U.S.C. § 1352, requires the Contractor to abide by this section and to place it’s language in all of it’s contracts:

a. No federal funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Federal Standard Form LLL, “Disclosure Form to report Lobbying,” in accordance with its instructions.

c. The Contractor shall require that the language of this article be included in the award documents for all subcontracts and that subcontractors shall certify and disclose accordingly.

4. **Debarment, suspension or other ineligibility:** The Contractor certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in this Contract by any governmental department or agency. The Contractor must notify the Department within 30 days in accordance with the notification requirements specified in Article III, section 11 of this Contract if the Contractor has been debarred by any governmental entity within the contract period. Debarment regulations are stated in Health and Human Services regulation 45 CFR Part 76.

5. **Environmental Impact:** The National Environmental Policy Act of 1969 (NEPA) (Public Law 91-190) establishes national policy goals and procedures to protect and enhance the environment. NEPA applies to all federal agencies and requires them to consider the probable environmental consequences of any major federal activity, including activities of other organizations operating with the concurrence or support of a federal agency. This includes grant-supported activities under this Contract if federal funds are involved. Additional environmental requirements include:

a. the institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order 11514;

b. the notification of violating facilities pursuant to Executive Order 11738 (all contracts, subcontracts, and subgrants in excess of $100,000);

c. the protection of wetlands pursuant to Executive Order 11990;

d. the evaluation of flood hazards in floodplains in accordance with Executive Order 11988;

e. the assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.);

f. the conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176 (c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§ 7401 et seq.);

g. the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523),

h. the protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93- 205) and;

i. the protection of the national wild and scenic rivers system under the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 *et seq*.).

6. **Human Subjects:** The Public Health Service Act, section 474(a), implemented by 45 CFR Part 46, requires basic protection for human subjects involved in Public Health Service grant supported research activities. Human subject is defined in the regulation as "a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual or identifiable private information." The regulation extends to the use of human organs, tissues, and body fluids from individually identifiable human subjects as well as to graphic, written, or recorded information derived from individually identifiable human subjects. The regulation also specifies additional protection for certain classes of human research involving fetuses, pregnant women, human in vitro fertilization, and prisoners. However, the regulation exempts certain categories of research involving human subjects which normally involve little or no risk. The exemptions are listed in 45 CFR Part 46.101(b). The protection of human subjects involved in research, development, and related activities is found in P.L. 93-348.

7. **Sterilization:** Health and Human Services and Public Health Service have established certain limitations on the performance of nonemergency sterilizations by Public Health Service grant-supported programs or projects that are otherwise authorized to perform such sterilizations. Public Health Service has issued regulations that establish safeguards to ensure that such sterilizations are performed on the basis of informed consent and that the solicitation of consent is not based on the withholding of benefits. These regulations, published at 42 CFR Part 50, Subpart B, apply to the performance of nonemergency sterilizations on persons legally capable of consenting to the sterilization. Federal financial participation is not available for any sterilization procedure performed on an individual who is under the age of 21, legally incapable of consenting to the sterilization, declared mentally incompetent, or is institutionalized.

8. **Abortions and Related Medical Services:** Federal financial participation is generally not available for the performance of an abortion in a grant-supported health services project. For further information on this subject, consult the regulation at 42 CFR Part 50, Subpart C.

9. **Recombinant DNA and Institutional Biosafety Committees:** Each institution where research involving recombinant DNA technology is being or will be conducted must establish a standing Biosafety Committee. Requirements for the composition of such a committee are given in Section IV of *Guidelines for Research Involving Recombinant DNA Molecules*, (49 FR 46266 or latest revision), which also discusses the roles and responsibilities of principal investigators and contractor institutions. *Guidelines for Research Involving Recombinant DNA Molecules and Administrative Practices Supplement* should be consulted for complete requirements for the conduct of projects involving recombinant DNA technology.

10. **Animal Welfare:** The *Public Health Service Policy on Humane Care and Use of Laboratory Animals By Awardee Institutions* requires that applicant organizations establish and maintain appropriate policies and procedures to ensure the humane care and use of live vertebrate animals involved in research activities supported by Public Health Service. This policy implements and supplements the U.S. *Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research, and Training* and requires that institutions use the *Guide for the Care and Use of Laboratory Animals* as a basis for developing and implementing an institutional animal care and use program. This policy does not affect applicable State or local laws or regulations which impose more stringent standards for the care and use of laboratory animals. All institutions are required to comply, as applicable, with the Animal Welfare Act as amended (7 U.S.C. 2131 et seq.) and other federal statutes and regulations relating to animals. These documents are available from the Office for Protection from Research Risks (OPRR), National Institutes of Health, Bethesda, MD 20892, (301) 496-7005.

11. **Contract Provisions:** The Contractor must include the following provisions in its contracts, as limited by the statements enclosed within the parentheses following each provision:

a. administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provides for such sanctions and penalties as may be appropriate. (Contracts other than small purchases. Small purchase involve relatively simple and informal procurement methods that do not cost more than $100,000 in aggregate.)

b. termination for cause and for convenience by the contractor or subgrantee including the manner by which it will be effected and the basis for settlement. (All contracts in excess of $10,000)

c. compliance with Executive Order 11246 of September 24, 1965 entitled "Equal Employment Opportunity," as amended by Executive Order 11375 of October 13, 1967 and as supplemented in Department of Labor regulations (41 CFR Chapter 60). (All construction contracts awarded in excess of

$10,000 by the Contractor and its contractors or subgrantees)

d. compliance with the Copeland “Anti-Kickback” Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR Part 3). (All contracts and subgrants for construction or repair)

e. compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts in excess of $2,000 awarded when required by Federal grant program legislation)

f. compliance with the Contract Work Hours and Safety Standards Act, sections 103 and 107, (40 U.S.C. 327-330) as supplemented by Department of Labor regulations (29 CFR Part 5). (Construction contracts awarded in excess of $2,000, and in excess of $2,500 for other contracts which involve the employment of mechanics or laborers)

g. notice of the federal awarding agency requirements and regulations pertaining to reporting.

h. notice of federal awarding agency requirements and regulations pertaining to patent rights with respect to any discovery or invention which arises or is developed in the course of or under such contract.

i. federal awarding agency requirements and regulations pertaining to copyrights and rights in data.

j. access by the Department, the Contractor, the Federal funding agency, the Comptroller General of the United States, or any of their duly authorized representatives to any books, documents, papers, and records of the Contractor which are directly pertinent to that specific contract for the purpose of making audit, examination, excerpts, and transcriptions.

k. compliance with all applicable standards, orders, or requirements of the Clear Air Act, section 306, (42 U.S.C. 1857(h)), the Clean Water Act, section 508, (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15). (Contracts, subcontracts, and subgrants of amounts in excess of $100,000)

l. mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163).

12. **(Governmental entities only) Merit System Standards:** The Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763), requires adherence to prescribed standards for merit systems funded with federal funds.

13. **Misconduct in Science:** The United States Public Health Service requires certain levels of ethical standards for all PHS grant-supported projects and requires recipient institutions to inquire into, investigate and resolve all instances of alleged or apparent misconduct in science. Issues involving potential criminal violations must be promptly reported to the HHS Office of Inspector General. (See regulations in 42 CFR Part 50, Subpart A)

END OF GENERAL PROVISIONS

ATTACHMENT B
SPECIAL PROVISIONS

TABLE OF CONTENTS

			Page
Article I	Definitions		1
Article II	Service Area		5
Article III	Marketing, Enrollment, Orientation, Education, and Disenrollment		5
A.	Marketing Activities		5
B.	Enrollment Process		6
C.	Member Orientation		9
D.	Member Education		11
E.	Disenrollment by Enrollee		15
F.	Disenrollment by CONTRACTOR		17
G.	Enrollee Transition Between Health Plans		19
H.	Enrollee Transition from FFS to Health Plan or from Health Plan to FFS		19
Article IV	Benefits		20
A.	In General		20
B.	Scope of Services		20
C.	Clarification of Covered Services		21
	1.	Emergency Services	21
	2.	Care Provided in Skilled Nursery Facilities	24
	3.	Hospice	25
	4.	Inpatient Hospital Services for Scheduled Admissions	26
	5.	Children in Custody of the Department of Human Services	26
	6.	Organ Transplantations	28
	7.	Mental Health Services	29
	8.	Developmental and Organic Disorders	29

9. Out-of-State Accessory Services 30
10. Non-Contractor Prior Authorizations 30
D. Additional Services for Enrollees with Special Health Care Needs 31
1. In General 31
2. Identification 31
3. Choosing a Primary Care Provider 31
4. Referrals and Access to Specialty Providers 32
5. Survey of Enrollees with Special Health Care Needs 32
6. Collaboration with Other Programs 33
7. Case Management and Coordination of Care Program 33
8. Specific Requirements for Children with Special Health Care Needs 34

Article V Delivery Network 35

A. Availability of Services 35
B. Subcontracts and Assurances 36
C. Contractor's Selection of Providers 39

Article VI Authorization of Services and Notices of Action 41

A. Service of Authorization and Notice of Action 41
B. Other Actions Requiring Notice of Action 46
C. Content of Notice of Action 47
D. Attachment to Notice of Actions - Written Appeal Request Form 49
E. Compensation for Utilization Management Activities 50
F. Medical Necessity Denials 50

Article VII Grievance Systems 50

A. Overall Grievance System 50
B. Special Requirements for Appeals 50
C. Standard Appeals Process 51
D. Process for Expedited Resolution of Appeals 54
E. Continuation of Benefits During Appeal or State Fair Hearing Processes 57
F. Duration of Continued or Reinstated Benefits 57
G. Reversed Appeal Resolutions 57
H. State Fair Hearings 58
I. Grievances 59
J. Documentation 61

Article VIII Enrollee Rights and Protections 62

A. Written Information on Enrollee Rights and Protections-General Requirements 62
B. Specific Enrollee Rights and Protections 62
C. Provider - Enrollee Communications 63

Article IX Contractor Assurances 64

A. Nondiscrimination 64
B. Member Services Function 64
C. Provider Services Function 65
D. Enrollee Liability 65
E. Access 65
F. Coordination and Continuity of Care 68
G. Billing Enrollees 71

H. Survey Requirements 72

Article X Measurement and Improvement Standards 73

A. Practice Guidelines 73
B. Quality Assessment and Performance Improvement Program 73

Article XI	Other Requirements	75
A.	Compliance with Public Health Service Act	75
B.	Advance Directives	75
C.	Fraud and Abuse Requirements	75
D.	Disclosure of Ownership and Control Information	76
E.	Safeguarding Confidential Information on Enrollees	76
F.	Disclosure of Provider Incentive Plans	77
Article XII	Payments	78
A.	Non-Risk Contract	78
B.	Payment Methodology	78
C.	Contract Maximum	78
D.	Medicare	78
E.	Third Party Liability (Coordination of Benefits)	80
F.	Third Party Responsibility (Including Worker's Compensation)	82
G.	Changes in Covered Services	83
H.	Clarification of Payment Responsibilities	83
Article XIII	Records and Reporting Requirements	87
A.	Health Information Systems	87
B.	Federally Required Reports	88
C.	Periodic Reports	89
D.	Data Certification	94
Article XIV	Compliance/Monitoring	95
A.	Audits	95
B.	Quality Monitoring by the DEPARTMENT	95
C.	External Quality Review	96
D.	Corrective Action	98
Article XV	Termination of the Contract	101
A.	Automatic Termination	101
B.	90-Day Termination Option	101

C.	Effect of Termination	101
D.	Assignment	103
Article XVI	Miscellaneous	103
A.	Integration	103
B.	Enrollees May Not Enforce Contract	103
C.	Interpretation of Laws and Regulations	103
D.	Adoption of Rules	103

Attachment B
Molina Healthcare of Utah
Effective January 1, 2006

For the purpose of the Contract all article, section, and subsection headings in these Attachments B and C are for convenience in referencing the provisions of the Contract. They are not enforceable as part of the text of the Contract and may not be used to interpret the meaning of the provisions that lie beneath them.

Special Provisions

Article I - Definitions

For the purpose of the Contract:

A. "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 IX - 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.

B. *"**Advance Directives**"* 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.

C. "Appeal" means a request for review of an Action.

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

E. "CHEC Eligible" means any Medicaid recipient 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.

F. "CHEC Program" or Child Health Evaluation and Care program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as defined in 42 CFR Part 441, Subpart B. Medicaid recipients who are eligible for the Non-Traditional Medicaid Plan are not eligible to receive EPSDT services. (See Attachment C, Covered Services, U.)

G. "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 1932(a)(2)(A) of the Social Security Act, 42 U.S.C., Section 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.

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

I. **"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.

J. **"Division of Health Care Financing"** or **"DHCF"** means the division within the Department of Health responsible for the administration of the Utah Medicaid program.

K. **"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) &# 160; Serious dysfunction of any bodily organ or part.

L. **"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.

M. **"Enrollee"** means any Medicaid recipient who is currently enrolled with this Health Plan and:
(1) who, at the time of enrollment resides within the geographical limits of the CONTRACTOR's Service Area;
(2) whose name appears on the DEPARTMENT's Eligibility Transmission as a new, reinstated, or retroactive Enrollee; and
~~(3)~~ who is accepted for enrollment by the CONTRACTOR according to the conditions set forth in this Contract excluding residents of the Utah State Hospital, Utah State Developmental Center, and long-term care facilities except as defined in Attachment C.

N. ***"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.

O. ***"Enrollment Area"*** or ***"Service Area"*** means the counties enumerated in Article II.

P. **"External Quality Review"** means the analysis and evaluation by an EQRO, of

aggregated information on quality, timeliness, and access to the health care services that a Health Plan, or its contractors, furnish to Medicaid recipients.

Q. **"External Quality Review Organization (EQRO)"** means an entity under contract with the DEPARTMENT to conduct an external quality review of the CONTRACTOR in accordance with Federal regulations governing external quality reviews.

R. "Family Member" means all Medicaid eligibles who are members of the same family living at home.

S. "Grievance" means an expression of dissatisfaction about any matter other than an action (as defined in this section). 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 a provider or employee, or failure to respect the Enrollee's rights.

T. "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.

U. "Grievance System" means an overall system that includes a grievance process, an appeal process, and access to the State's fair hearing system.

V. "Health Plan" means a federally defined Prepaid Inpatient 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 clients.

W. ***"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 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.

X. ***"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.

Y. "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.

Z. ***"Non-risk Contract"*** means a contract under which the CONTRACTOR is not at financial risk for changes in utilization or for costs incurred under the Contract that do not exceed the DEPARTMENT's Payment Limit. The Payment Limit is the total amount Medicaid would have paid, in aggregate, for the same services on a fee-for-service basis net of third party payments.

AA. ***"Non-Traditional Medicaid Plan"*** means the reduced benefit plan provided to Medicaid eligibles age 19 through 64 who are in certain TANF, Medically Needy, and Transitional Medicaid aid categories. Services covered under the reduced benefit plan are similar to the Traditional Medicaid Plan with some limitations and exclusions.

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

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

DD. ***"Physician Incentive Plan"*** means any compensation between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to Enrollees in the organization.

EE. ***"Post-stabilization 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.

FF. ***"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.

GG. ***"Prepaid Inpatient Health Plan"*** 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.

HH. **"Prepaid Mental Health Plan"** means the mental health centers that contract with the DEPARTMENT to provide inpatient and outpatient mental health services to Medicaid clients living within each mental health center's jurisdiction.

II. **"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.

JJ. **"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.

KK. **"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.

LL. **"Restriction Program"** means the Federally mandated program (42 CFR 431.54(e)) for Medicaid clients 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.

MM. **"State Plan"** means the 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).

NN. **"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.

OO. **"Traditional Medicaid Plan"** means the scope of services contained in the State Plan provided to Medicaid eligibles who fall under one of the following eligibility groups:

(1) Section 1931 children and related poverty level populations (TANF/AFDC);
(2) Section 1931 pregnant women (TANF/AFDC);
(3) Blind/disabled children and related populations (SSI);
(4) Blind/disabled adults and related populations (SSI);
(5) Aged and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);
(6) Foster care children;
(7) Individuals who qualify for Medicaid by paying a spenddown and are under age 19 or are also aged or disabled;
(8) Pregnant women (non-TANF/AFDC)

Article II - Service Area

The Service Area is limited to the counties of Beaver, Box Elder, Cache, Davis, Garfield, Iron, Juan, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Utah, Washington, Wayne, and Weber.

Article III - Marketing, Enrollment, Orientation, and Disenrollment

A. Marketing Activities

1. The DEPARTMENT does not permit the CONTRACTOR to conduct direct or indirect marketing as defined in this section. In this Article III, Section A - Marketing

Activities, "CONTRACTOR" includes any of the CONTRACTOR's employees, affiliated providers, agents, or contractors.

2. "Marketing" means any communication, from the CONTRACTOR to a Potential Enrollee, that can reasonably be interpreted as intended to influence the Potential Enrollee to enroll in the CONTRACTOR's Medicaid product, or either to not enroll in, or to disenroll from, another Health Plan's Medicaid product.

3. "Marketing materials" means materials that are produced in any medium, by or on behalf of the CONTRACTOR and can reasonably be interpreted as intended to market to Potential Enrollees. The CONTRACTOR cannot, either directly or indirectly, conduct door-to-door, telephonic or other "cold call" marketing activities.

   a. These three marketing practices are prohibited whether conducted by the CONTRACTOR itself ("directly") or by an agent or independent contractor ("indirectly").

   b. Cold call marketing means any unsolicited personal contact with a potential Enrollee for the purpose of marketing.

   c. All other non-requested marketing approaches to Medicaid clients by the CONTRACTOR are also prohibited unless specifically approved in advance by the DEPARTMENT.

4. The CONTRACTOR may not influence enrollment in conjunction with the sale or offering of any private insurance.

5. The CONTRACTOR will not distribute any materials that include statements that will be considered inaccurate, false, or misleading including, but not limited to, any assertion or statement (whether written or oral) that the Potential Enrollee must enroll in Healthy U in order to obtain benefits or in order to not lose benefits; or that Healthy U is endorsed by CMS, the Federal or State government, or similar entity.

B. Enrollment Process

1. Enrollee Choice

   a. The DEPARTMENT will offer Potential Enrollees a choice among all Health Plans available in the Enrollment 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.

2. Period of Enrollment

a. Each Enrollee will be enrolled for the period of the Contract or the period of Medicaid eligibility or until such person disenrolls or is disenrolled, whichever is earlier.

b. Until the DEPARTMENT notifies the CONTRACTOR that an Enrollee is no longer Medicaid eligible, the CONTRACTOR may assume that the Enrollee continues to be eligible.

c. Each Enrollee will be automatically re-enrolled at the end of each month unless that Enrollee notifies the DEPARTMENT's Health Program Representative of an intent not to re-enroll in the Health Plan prior to the benefit issuance date.

3. Open Enrollment

The CONTRACTOR will have a continuous open enrollment period that meets the requirements of Section 1301(d) of the Public Health Service Act. The DEPARTMENT will certify, and the CONTRACTOR agrees to accept individuals who are eligible to be enrolled in the Health Plan under the provisions of this Contract:

a. in the order in which they apply; and

b. without restrictions unless authorized by the DEPARTMENT.

4. No Health Screening

The DEPARTMENT and the CONTRACTOR agree that no Potential Enrollee will be pre-screened or selected by either party for enrollment on the basis of pre-existing health problems or on the basis of race, color, national origin, disability or age.

5. Independent Enrollment

Each Medicaid eligible can be enrolled with or disenrolled from the Health Plan, independent of any other Family Member's enrollment or disenrollment.

6. Representative Population

The CONTRACTOR will service a population representative of the categories of eligibility within the area it serves.

7. Eligibility Transmission

a. In general

(1) Before the close of business each day, the DEPARTMENT will provide to the CONTRACTOR an Eligibility Transmission which is an electronic file that includes individuals which the DEPARTMENT certifies as Medicaid eligible and who enrolled in the Health Plan. Eligibility transmissions include new Enrollees,

reinstated Enrollees, retroactive Enrollees, terminated Enrollees and Enrollees whose eligibility information results in a change to a critical field.

(2) The Eligibility Transmission will be in accordance with the Utah Health Information Network (UHIN) standard.

(3) The DEPARTMENT represents and warrants to the CONTRACTOR that the appearance of an individual's name on the Eligibility Transmission, other than a deleted Enrollee, will be conclusive evidence for purposes of this Contract, that such person is enrolled in the program and qualifies for medical assistance under Medicaid Title XIX.

b. New Enrollees

(1) New Enrollees are enrolled in this Health Plan until otherwise specified; these Enrollees will not appear on future transmissions unless there is a change in a critical field.

(2) Critical fields are coverage dates, recipient name, date of birth, date of death, sex, social security number, case information, address, telephone number, payment code, coordination of benefits, and the Enrollee's provider under the Restriction Program.

(3) Enrollees with a spenddown requirement will appear on the eligibility transmission on a month by month basis after the spenddown is met.

c. Retroactive Enrollees

Retroactive Enrollees are those who were Enrollees previous to the current month. Retroactive Enrollees include newborn Enrollees or Enrollees who have been reported in one payment category in a previous month, but have been

changed to a new payment category for that previous month when they are made eligible for the current month.

d. Reinstated Enrollees

Reinstated Enrollees are those who were enrolled for the previous month and also closed at the end of the previous month. These Enrollees are eligible retroactively to the beginning of the current month.

e. Terminated Enrollees

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

8. Change of Enrollment Procedures

a. The CONTRACTOR will be advised of anticipated changes in DEPARTMENT policies and procedures as they relate to the enrollment process and their comments will be solicited.

b. The CONTRACTOR agrees to be bound by such changes in DEPARTMENT policies and procedures that are mutually agreed upon by the CONTRACTOR and the DEPARTMENT.

C. Member Orientation

1. Initial Contact - - General Orientation

a. The CONTRACTOR will 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 will make a good faith effort, as evidenced in written or electronic records, 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 with this Health Plan.

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

(2) The initial contact will be in person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person by telephone) and will inform the Enrollee of the CONTRACTOR's rules and policies.

c. The CONTRACTOR will 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 will provide, at a minimum, the following information to the Enrollee or Potential Enrollee appropriate to the Enrollee's eligibility (Traditional versus Non-Traditional Medicaid):

(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 client's rights and responsibilities as an Enrollee of this 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.

2. Identification of Enrollees with Special Health Care Needs

a. During the initial contact with each Enrollee, the CONTRACTOR's representative will use a process that will identify children and adults with special health care needs.

b. The CONTRACTOR's representative will clearly describe to each Enrollee during the initial contact the process for requesting specialist care.

c. When an Enrollee is identified as having special health care needs, the CONTRACTOR's Representative will forward this information to a CONTRACTOR's individual with knowledge of coordination of care and services necessary for such Enrollees. The CONTRACTOR's individual with knowledge of coordination of care for Enrollees with special health care needs will make a good faith effort to contact Enrollees within ten working days after identification to begin coordination of health care needs, if necessary.

d. The CONTRACTOR will not discriminate on the basis of health status or the need for health care services.

e. The DEPARTMENT's Health Program Representatives are responsible to forward information, including risk assessments, that identify Enrollees with special health care needs and limited language proficiency needs to the CONTRACTOR in a timely manner, coinciding with the daily Eligibility Transmission as much as possible.

3. ***Enrollees Receiving Out-of-Plan Care Prior to Orientation***

If the Enrollee receives Covered Services by an out-of-plan provider after the first day of the month in which the client's enrollment became effective, and if a CONTRACTOR orientation, either in-person or by telephone (or in writing, but only if reasonable attempts have been made to make the contact in person or by telephone), has not taken place prior to receiving such services, the CONTRACTOR is responsible for payment of the services rendered provided the DEPARTMENT informs the CONTRACTOR by the 20th of any month prior to the month that enrollment with the Health Plan begins.

D. Member Education

1. Enrollee Information Requirements

a. In General

(1) The CONTRACTOR will write all Enrollee and Potential Enrollee informational, instructional, and educational materials, including the CONTRACTOR's member handbook, in a manner and format that may be easily understood; e.g. at no greater than a sixth grade reading level.

(2) Once per year, the CONTRACTOR will notify all Enrollees of their right ro request and obtain the CONTRACTOR's member handbook.

b. Prevalent Language

(1) The CONTRACTOR will 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.

(2) The CONTRACTOR will 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.

c. Alternative formats

The CONTRACTOR will make Enrollee informational and instructional materials, including the member handbook, available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., audio tapes).

2. Member Handbook

a. The CONTRACTOR will produce a member handbook that will be submitted

to the DEPARTMENT for review and approval before distribution. The DEPARTMENT will notify the CONTRACTOR in writing of its approval or disapproval within ten working days after receiving the member handbook unless the DEPARTMENT and CONTRACTOR agree to another time frame. If the DEPARTMENT does not respond within the agreed upon time frame, the CONTRACTOR may deem such materials are approved.

b. If there are changes to the content of the material in the handbook, the CONTRACTOR will update the member handbook and submit a draft to the DEPARTMENT for review and approval before distribution to its Enrollees.

c. At a minimum, the member handbook will explain in clear terms the following information:

(1) The amount, duration, and scope of benefits provided by the CONTRACTOR delineating Traditional versus Non-Traditional Medicaid scopes of service in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;

(2) Instructions on where and how to obtain Covered Services, including any service authorization requirements; how and under what circumstances out-of-area services are covered; policy on referrals to speciality care and for other benefits not furnished by the Enrollee's primary care provider; and procedures for resolving Enrollee issues related to authorization of coverage or payment for services;

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

(a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to definitions in 42 CFR 438.114(a);

(b) The fact that prior authorization is not required for emergency services;

(c) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;

(d) The location of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the Contract; and

(e) The fact that the Enrollee has the right to use any hospital or other setting for emergency care.

(4) The post-stabilization care services rules set forth at 42 CFR 422.113(c);

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

(6) The importance of establishing a primary care relationship with an affiliated provider, and processes for selecting or changing primary care providers;

(7) Description of Enrollee cost-sharing requirements (if 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 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;

(11) 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;

(12) 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;

(13) 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 physicians, specialists, and hospitals;

(14) Any restrictions on the Enrollee's freedom of choice among network providers;

(15) Enrollee rights and protections, as specified in Article VIII of this Contract;

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

(a) the right to file Grievances and Appeals;

(b) the requirements and timeframes for filing a Grievance or Appeal;

(c) the availability of assistance in the filing process;

(d) the toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

(e) the fact that, when requested by the Enrollee, benefits will continue if the Enrollee files an Appeal or a request for a State fair hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee;

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

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

(a) the CONTRACTOR's policy for selection of providers (staff and subcontractors) and what is required of them,

(b) the CONTRACTOR's grievance system,

(c) the CONTRACTOR's confidentiality policy,

(d) that information is available on request regarding the CONTRACTOR's Physician Incentive Plan (if the CONTRACTOR has an incentive plan), and

(e) that a copy of the CONTRACTOR's preferred practice guidelines is also available to Enrollees on request;

(19) Circumstances in which the Enrollee may be responsible for payment of services may include:

(a) obtaining a service that is not a benefit of the plan or

(b) obtaining services not authorized by the CONTRACTOR (in either situation, the Enrollee should be liable only if the Enrollee gave advance written consent to the provider);

(c) Appeal or State fair hearing decisions adverse to the Enrollee when benefits (services) were continued during the Appeal or State fair hearing process at the Enrollee's request; or

(d) ineligibility for Medicaid for any portion of the time period during which services were provided;

(20) Description of Member Services function; and

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

3. Notification to Enrollees of Policies and Procedures

a. Changes to Policies and Procedures

The CONTRACTOR will give each Enrollee written notice at least 30 days before the intended effective date of change to significant information in the CONTRACTOR's member handbook.

b. Annual Education on Emergency Care and Grievance Procedures

The CONTRACTOR will annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to register an Appeal or Grievance.

4. Notification of Changes in Provider Network

The CONTRACTOR will 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.

E. Disenrollment by Enrollee

1. Limited Disenrollment Requirements

The DEPARTMENT has a requirement that requires Health Plan Enrollees to stay with the same Health Plan for up to twelve (12) months.

2. Without Cause Exception to 12 Month Enrollment with Same Health Plan Restriction

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

a. within the first three months of each enrollment period with each Health Plan, or

b. if no more than three months have passed since the month the client's Medicaid card has a Health Plan printed on it, or

c. during the open enrollment period as defined by the DEPARTMENT.

3. With Cause Exceptions to 12 Month Enrollment with Same Health Plan

Enrollees may request to transfer from one Health Plan to another at any time during their twelve (12) month restriction period for the following good cause reasons:

a. Enrollee moves out of the Health Plan's service area;

b. Current Health Plan is no longer available;

c. Change in third party liability insurance status;

d. Health Plan choice not available when Enrollee first made selection;

e. Enrollee needs related services, some of which are not available in the Health Plan's network, and Enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk;

f. Poor quality of care;

g. Lack of access to Covered Services;

h. Lack of access to providers experienced in dealing with Enrollee's health care needs;

i. Enrollee becomes emancipated or is added to a different Medicaid case;

j. Difficulty getting continuity of care with provider of choice (i.e., foster care Enrollee's doctor switches Health Plans); or

k. Health Plan does not, because of moral or religious objections, cover the service the Enrollee seeks.

4. Process for Requesting Health Plan Change

a. The Enrollee may request to switch Health Plans by submitting an oral or written request to the State. The Enrollee must declare the Health Plan in which he or she wishes to enroll should the disenrollment be approved.

b. The DEPARTMENT will review each request to determine if the request meets the criteria for cause and if so, will allow the Enrollee to switch to another Health Plan. If the request does not meet the criteria for cause, or if the concern is with a provider and not the Health Plan, the DEPARTMENT will deny the disenrollment request and inform the Enrollee of his or her rights to request a State fair hearing.

c. If the DEPARTMENT fails to make a determination within ten (10) calendar days after receiving the disenrollment request, the disenrollment is considered approved. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the enrollee filed the request.

d. The disenrollment will 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.

5. Enrollees in an Inpatient Hospital Setting

The DEPARTMENT agrees that if 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 will commence following discharge. If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a deleted Enrollee on the CONTRACTOR Eligibility Transmission or he or she is otherwise disenrolled under this Contract, the CONTRACTOR will remain financially responsible for such care until discharge.

6. Annual Study of Enrollees who Disenrolled

Annually, the DEPARTMENT and CONTRACTOR will work cooperatively to conduct an analysis of Enrollees who have voluntarily disenrolled from this Health Plan. The results of the analysis will include explanations of patterns of disenrollments and strategies or a corrective action plan to address unusual rates or patterns of disenrollment. The DEPARTMENT will inform the CONTRACTOR of such disenrollments.

F. Disenrollment Initiated by CONTRACTOR

1. Cannot Disenroll for Adverse Change in Enrollee's Health

The CONTRACTOR may not terminate enrollment 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).

2. Valid Reasons for Disenrollment

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

a. For reasons specifically identified in the CONTRACTOR's member handbook.

b. When the Enrollee ceases to be eligible for medical assistance under the State Plan, in accordance with Title 42 USCA, 1396, et. seq., and as finally determined by the DEPARTMENT.

c. Upon termination or expiration of the Contract.

d. Death of the Enrollee.

e. Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract.

f. 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. Approval by DEPARTMENT Required

To initiate disenrollment of an Enrollee's participation with this Health Plan, the CONTRACTOR will provide the DEPARTMENT with documentation justifying the proposed disenrollment. The DEPARTMENT will approve or deny the disenrollment request in writing within thirty (30) days of receipt of the request. Failure by the DEPARTMENT to deny a disenrollment request within such thirty (30) day period will constitute approval of such disenrollment requests.

4. Enrollee's Right to File a Grievance

If the DEPARTMENT approves the CONTRACTOR's disenrollment request, the CONTRACTOR will give the Enrollee thirty (30) days written notice of the proposed disenrollment, and will notify the Enrollee of his or her opportunity to invoke the CONTRACTOR's Grievance Process. The CONTRACTOR will give a copy of the written notice to the DEPARTMENT at the time the notice is sent to the Enrollee.

5. Refusal of Re-enrollment

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

6. Automatic Re-enrollment

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

G. Enrollee Transition Between Health Plans

1. Will Accept Pre-Enrollment Prior Authorizations

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and an enrollee transitions between Health Plans prior to the delivery of such Covered Service, the receiving Health Plan will 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. (See Article XII, Payments, Section H, Clarification of Payment Responsibilities, Subsection 5, for inpatient, home health services, and medical equipment explanations.)

2. Will Provide Medical Records to Enrollee's New Health Plan

When enrollees are transitioned between Health Plans the relinquishing Health Plan's provider will submit, upon request of the new Health Plan's provider, any critical medical information about the transitioning enrollee 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 (e.g. diabetic, hemophilic, HIV positive).

H. Enrollee Transition From FFS to Health Plan or From Health Plan to FFS

1. CONTRACTOR Will Accept Pre-Enrollment Prior Authorizations

For Covered Services other than inpatient, home health services, and medical equipment, if authorization has been given for a Covered Service and a Medicaid client transitions from Medicaid fee-for-service to enrollment with the CONTRACTOR's health plan prior to the delivery of such Covered Service, the CONTRACTOR will 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. (See Article XII, Payments, Section H, Clarification of Payment Responsibilities, Subsection 6, for inpatient, home health services, and medical equipment explanations.)

2. DEPARTMENT Will Accept CONTRACTOR's Prior Authorization

For Covered Services other than inpatient, home health services, and medical equipment, 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 will be bound by the CONTRACTOR's prior authorization until the DEPARTMENT has evaluated the medical necessity of the service and agrees with the CONTRACTOR's fee-for-service prior authorization or has made a different determination. (See Article XII, Benefits, Section H, Clarification of Payment Responsibilities, Subsection 6, for inpatient, home health services, and medical equipment explanations.)

3. Will Provide Medical Records to Enrollee's Health Plan or to the DEPARTMENT

When enrollees are transitioned from Health Plan to fee-for-service or from fee-for-service to Health Plan, the relinquishing entity (Health Plan or DEPARTMENT) will submit, upon request of the new entity, any critical medical information about the transitioning Medicaid client 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 (e.g. diabetic, hemophilic, HIV positive).

Article IV - Benefits

A. In General

1. The CONTRACTOR will provide to Enrollees under this Contract, directly or through arrangements with subcontractors, all Medically Necessary Covered Services described in Attachment C as promptly and continuously as is consistent with generally accepted standards of medical practice.

2. The CONTRACTOR will 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 (as set forth in 440.230). The CONTRACTOR will ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

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

4. The CONTRACTOR may place appropriate limits on a service on the basis of criterion applied under the 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.

5. The subcontractors will follow generally accepted standards of medical care in diagnosing Enrollees who request services from the CONTRACTOR.

B. Scope of Services

1. Responsible for all Benefits in Attachment C (Covered Services)

Except as otherwise provided for cases of Emergency Services, the CONTRACTOR has the exclusive right and responsibility to arrange for all benefits listed in Attachment C. The CONTRACTOR is responsible for payment of Emergency Services 24 hours a day and 7 days a week whether the service was provided by a network or out-of-network provider and whether the service was provided in or out of the CONTRACTOR's Service Area.

2. Changes to Benefits

Amendments, revisions, or additions to the State Plan or to State or Federal regulations, guidelines, or policies and court or administrative orders will, insofar as they affect the scope or nature of benefits available to Enrollees, be amendments to the Covered Services under Attachment C. The DEPARTMENT will notify the CONTRACTOR, in writing, of any such changes and their effective date.

C. Clarification of Covered Services

1. Emergency Services

a. In General

(1) The CONTRACTOR will provide coverage for Emergency Services without regard to prior authorizations or the emergency care provider's contractual relationship with the CONTRACTOR. The CONTRACTOR will inform its 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. An Enrollee who has 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.

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

(3) The CONTRACTOR will pay for services where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in 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; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

(4) The CONTRACTOR may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.

b. Determining Liability for Emergency Services

The CONTRACTOR may not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition.

(1) Presence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the CONTRACTOR will pay for both the services involved in the screening examination and the services required to stabilize the Enrollee.

(2) Emergency services continue until the Enrollee can be safely discharged or transferred.

The CONTRACTOR will pay for all Emergency Services that are Medically Necessary until the clinical emergency is stabilized. This includes all treatment that may be 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. If there is a disagreement between a hospital and the CONTRACTOR concerning whether the Enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgement 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.

(3) Absence of a clinical emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition did not exist, then the determining factor for payment liability should be whether the Enrollee had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR will review the presenting symptoms of the Enrollee and will pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard.

(4) Referrals

When an Enrollee's Primary Care Physician or other plan representative instructs the Enrollee to seek emergency care in or out of network, the CONTRACTOR is responsible for payment of the medical screening examination and for other Medically Necessary Emergency Services, without regard to whether the Enrollee meets the prudent layperson standard.

(5) Notification

The CONTRACTOR may not refuse to cover Emergency Services because the emergency room provider, hospital, or fiscal agent did not notify the CONTRACTOR of the Enrollee's screening and treatment within ten calendar days of presentation for Emergency Services.

c. Post-Stabilization Services

The CONTRACTOR will comply with Medicare guidelines for post-stabilization of care as found in 42 CFR 422.113(c). Generally, Post-Stabilization Services begin when an Enrollee is admitted for an inpatient hospital stay after Emergency Services to evaluate or stabilize the Emergency Medical condition have been provided in the Emergency Room.

However, in situations where the hospital demonstrates the Enrollee received Emergency Services related to an Emergency Medical Condition during the inpatient admission, the CONTRACTOR will reimburse the hospital in accordance with regulations

governing Emergency Services as outlined in item b., Emergency Services, above.

(1) **Pre-approved Post-Stabilization Services:** The CONTRACTOR is financially responsible for Post-stabilization Services obtained within or outside the CONTRACTOR's plan that are pre-approved by a CONTRACTOR provider or representative.

(2) **Post-Stabilization Services - - Not Pre-Approved – but CONTRACTOR is Responsible:** The CONTRACTOR is financially responsible for Post-stabilization Services obtained within or outside the CONTRACTOR organization that are not pre-approved by a CONTRACTOR provider or other 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.

The CONTRACTOR is financially responsible for Post-stabilization Services obtained within or outside the CONTRACTOR organization that are not pre-approved by a CONTRACTOR

provider or other CONTRACTOR representative, but are administered to maintain, improve or resolve the Enrollee's stabilized condition if:

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

(b) the CONTRACTOR cannot be contacted;

(c) the CONTRACTOR representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a CONTRACTOR physician is not available for consultation. In this situation, the CONTRACTOR will 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 criteria outlined in 42 CFR 422.113(c)(3) is met:

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

(ii) a CONTRACTOR physician assumes responsibility for the Enrollee's care through transfer;

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

(iv) the Enrollee is discharged.

2. Care Provided in Skilled Nursing Facilities

a. In General: Stays Lasting 30 Days or Less

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities 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 the determination if the patient will require the services of a nursing facility for fewer or greater than 30 days.

b. Process for Stays Longer than 30 Days

When the prognosis of an Enrollee indicates that long term care greater than 30 days will be required, the following process will occur:

(1) The CONTRACTOR will notify the Enrollee, hospital discharge planner, and nursing facility that the CONTRACTOR will not be responsible for the services provided for the Enrollee during the stay at the skilled nursing facility.

(2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care (BMHC) of this determination and the BMHC will change the status of the Enrollee to fee-for-service.

c. Process for Stays Less than 30 Days

When the prognosis of skilled nursing facility services is anticipated to be less than 30 days, but during the 30-day period the CONTRACTOR determines that the Enrollee will require skilled nursing facility services for greater than 30 days, the following process will be in effect:

(1) The CONTRACTOR will notify the nursing facility that a determination has been made that the Enrollee will require services for more than 30 days.

(2) The CONTRACTOR will notify the DHCF, Bureau of Managed Health Care, of the determination that the Enrollee will require services in a nursing facility for more than 30 days.

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

3. Hospice

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 Enrollee will be offered 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/MR, or a freestanding hospice facility, the Health Plan is responsible to 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. At the point the Health Plan determines that the Enrollee will require care in the hospice facility for greater than 30 days, the Health Plan will notify the Enrollee, hospice agency, and hospice facility that the Health Plan will no longer be responsible for hospice services. The CONTRACTOR will also notify the DEPARTMENT's Bureau of Managed Health Care (BMHC) of this determination. The BMHC will change the status of the Enrollee to fee-for-service.

c. The CONTRACTOR is responsible 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/MR, or freestanding hospice facility until the Enrollee is disenrolled from the Health Plan by the BMHC.

4. Inpatient Hospital Services for Scheduled Admissions

a. If a CONTRACTOR's provider admits an Enrollee for inpatient hospital care and has followed the CONTRACTOR's requirements for the admission, the CONTRACTOR has the responsibility for all services needed by the Enrollee during the hospital stay that are ordered by the CONTRACTOR's provider. Needed services include but are not limited to diagnostic tests, pharmacy, and physician services, including services provided by psychiatrists.

b. If diagnostic tests conducted during the inpatient stay reveal that the Enrollee's condition is outside the scope of the CONTRACTOR's responsibility, the CONTRACTOR remains financially responsible for the Enrollee until the Enrollee is discharged or until responsibility is transferred to another appropriate entity and the entity agrees to take financial responsibility, including negotiating a payment for services.

c. If the Enrollee is discharged and needs further services, the admitting CONTRACTOR will coordinate with the other appropriate entity to ensure continued care is provided. The CONTRACTOR and appropriate entity will work cooperatively in the best interest of the Enrollee. The appropriate entity includes, but is not limited to, a Prepaid Mental Health Plan.

5. Children in Custody of the Department of Human Services

a. In General

(1) The CONTRACTOR will work with the Division of Child and Family Services (DCFS) or the Division of Youth Corrections (DYC) 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 will ensure these children receive timely access to appointments through coordination with DCFS or DYC. The CONTRACTOR will have available providers who have experience and training in abuse and neglect issues.

(2) The CONTRACTOR or its providers will make every reasonable effort to ensure that a child who is in custody of the Department of Human Services 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 will facilitate timely appointments with the provider of record to ensure continuity of care for the child.

(3) 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 the DHS staff in performing these functions by communicating with the CONTRACTOR.

b. Schedule of Visits

(1) Where physical and/or sexual abuse is suspected

In cases where the child protection worker suspects physical and/or sexual abuse, the CONTRACTOR will 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 will ensure thechild has access to a provider who can provide an appropriate examination within the 24 hour period.

(2) All other cases

In all other cases, the CONTRACTOR will ensure that the child has access to an initial health screening within five calendar days of notification that the child was removed from the home. The CONTRACTOR will ensure this exam identifies any health problems that might determine the selection of a suitable placement, or require immediate attention.

(3) CHEC exams

In all cases, the CONTRACTOR will ensure that the child has 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 will ensure the child has access to a CHEC screening according to the CHEC periodicity schedule until age six, then annually thereafter.

6. Organ Transplantations

a. In General

All organ transplantation services are the responsibility of the CONTRACTOR for all Enrollees in accordance with the criteria set forth in Rule R414-10A of the Utah Administrative Code, unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 7 of this Contract. The DEPARTMENT's criteria will be provided to the CONTRACTOR.

b. Specific Organ Transplantations Covered

The following transplantations are covered for Enrollees under the Traditional Medicaid Plan as described in Rule 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. Transplantations for Enrollees under the Non-Traditional Medicaid Plan are limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung.

c. Psychosocial Evaluation Required

(1) Enrollees who have applied for organ transplantations, except cornea or kidney, will undergo a comprehensive psycho-social evaluation by a board-certified or board-eligible psychiatrist. The evaluation will 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 18 years of age will undergo a psycho-social evaluation that includes a comprehensive history regarding substance abuse, and past and present compliance with medical treatment.

(2) If a request is made for a transplantation not listed above, the CONTRACTOR will contact the DEPARTMENT. Such requests will be addressed as set forth in R414-10A-23.

d. Out-of-State Transplantations

When the CONTRACTOR arranges the transplantation to be performed out-of- state, the CONTRACTOR is responsible for coverage of food, lodging, transportation and airfare expenses for the Enrollee and attendant. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation and airfare expenses.

7. Mental Health Services

a. When an Enrollee presents with a possible mental health condition to his or her CONTRACTOR primary care physician, 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 CONTRACTOR primary care provider or referred to the Enrollee's Prepaid Mental Health Plan when more specialized services are required for the Enrollee. CONTRACTOR primary care providers may seek consultation from the Prepaid Mental Health Plan when the primary care provider chooses to manage the Enrollee's symptoms.

b. An independent panel comprised of specialists appropriate to the concern will be established by the DEPARTMENT with representatives from the CONTRACTOR and Prepaid Mental Health Plan to adjudicate disputes regarding which entity (the CONTRACTOR or Prepaid Mental Health Plan) is responsible for payment and/or treatment of a condition. The panel will be convened on a case-by-case basis. The CONTRACTOR and Prepaid Mental Health Plan will adhere to the final decision of the panel.

8. Developmental and Organic Disorders

a. Covered Services for Child Enrollees through Age 20

(1) The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for child Enrollees with developmental (ICD-9 codes 299.0 through 299.11, developmental disorders included within the range 299.8 through 299.91, and 317 through 319.9) and organic diagnoses (ICD-9 codes 290 through 290.99, 293 through 294.99, and and 310 through 310.9) including, but not limited to, diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

(2) The CONTRACTOR is responsible for all psychological services for child Enrollees with developmental or organic disorders and all other diagnoses not covered by a Prepaid Mental Health Plan.

b. Covered Services for Adult Enrollees Age 21 and Older

The CONTRACTOR is responsible for all inpatient and physician outpatient Covered Services for adult Enrollees with developmental (ICD-9 codes 299.0 through 299.11, developmental disorders included within the range 299.8 through 299.91, and 317 through 319.9) and organic diagnoses (ICD-9

codes 290 through 290.99, 293 through 294.99 and 310 through 310.9) including diagnostic work-ups and other medical care such as medication management services related to the developmental or organic disorder.

c. Non-covered Services

(1) Psychological evaluations and testing including neuropsychological evaluations and testing for adult Enrollees is not the responsibility of the CONTRACTOR.

(2) Habilitative and behavioral management services are not the responsibility of the CONTRACTOR. If habilitative services are required, the Enrollee should be referred to the Division of Services for People with Disabilities (DSPD), the school system, the Early Intervention Program, or similar support program or 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 acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings."

d. Responsibility of the Prepaid Mental Health Plan

The Prepaid Mental Health Plan is responsible for the treatment of the mental illness to individuals with both an organic and a psychiatric diagnosis or with both a developmental and a psychiatric diagnosis.

9. Out-of-State Accessory Services

When the CONTRACTOR arranges a Covered Service to be performed out-of-state, the CONTRACTOR is responsible for coverage of airfare, food and lodging for the Enrollee and one attendant during the stay at the out-of-state facility. Ground transportation costs only from the airport to the hotel or hospital and back to the airport, one time only are also the responsibility of the CONTRACTOR. The CONTRACTOR will follow, at a minimum, the DEPARTMENT's criteria for coverage of food, lodging, transportation, and airfare expenses.

10. Non-Contractor Prior Authorizations

a. Prior Authorizations - General

The CONTRACTOR will 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.

***b. When the CONTRACTOR has not Authorized the Service and the Provider is not a Participating* Provider**

For services that require a prior authorization, the CONTRACTOR will 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; and

(2) the DEPARTMENT issued a prior authorization for an Enrollee to the servicing provider; and

(3) the provider filed an Appeal with the CONTRACTOR within the required time frame for filing an Appeal; and

(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) in the hearing process it is determined that the service rendered was a Medically Necessary service covered under this Contract, and that the CONTRACTOR will be responsible for payment of the claim.

D. Additional Services for Enrollees with Special Health Care Needs

1. In General

The CONTRACTOR will make case management programs available to Enrollees identified with special health care needs. The CONTRACTOR will ensure there is access to all Medically Necessary Covered Services to meet the health needs of Enrollees with Special Health Care Needs. Individuals with special health care needs are those 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.

2. Identification

The CONTRACTOR will identify Enrollees with Special Health Care Needs using a process at the initial contact made by the CONTRACTOR Representative to educate the client and will offer the client care coordination or case management services. Care coordination services are services to assist the client in obtaining Medically Necessary Covered Services from the CONTRACTOR or another entity if the medical service is not covered under the Contract.

3. Choosing a Primary Care Provider

The CONTRACTOR will have a mechanism to inform caregivers and, when

appropriate, Enrollees with Special Health Care Needs about primary care providers who have training in caring for such Enrollees so that an informed selection of a provider can be made. The CONTRACTOR will have primary care providers with skills and experience to meet the needs of Enrollees with Special Health Care Needs. For Enrollees determined to need a course of treatment or regular care monitoring, the CONTRACTOR will 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 will allow an appropriate specialist to be the primary care provider but only if the specialist has the skills to monitor the Enrollee's preventive and primary care services.

4. Referrals and Access to Specialty Providers

(1) The CONTRACTOR will ensure 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 will have a process to allow the Enrollee to receive Covered Services from a qualified specialist who may not be affiliated with the CONTRACTOR. The CONTRACTOR will reimburse the specialist for such care at no less than Medicaid's rate for the service when the service is rendered. The process for requesting specialist's care will be clearly described by the CONTRACTOR and explained to each Enrollee during the initial contact with the Enrollee.

(2) If the CONTRACTOR restricts the number of referrals to specialists, the CONTRACTOR will not penalize those providers who make such referrals for Enrollees with special health care needs.

5. Survey of Enrollees with Special Health Care Needs

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will 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 survey process, including the survey instrument, will be standardized and developed collaboratively between the DEPARTMENT and all contracting Health Plans. The DEPARTMENT will analyze the results of the surveys. The results and analysis of

the surveys will be reviewed by the CONTRACTOR's quality assurance committee for action.

6. Collaboration with Other Programs

a. The CONTRACTOR will implement procedures to share with other PIHPs and PAHPs, serving Enrollees with Special health Care Needs the results of its identification and assessment of each Enrollee's needs to prevent duplication of those activities.

b. If the Enrollee with Special Health Care Needs is enrolled in the 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 will collaborate with the appropriate program person, i.e., the targeted case manager, etc., for that program once the program person has contacted the CONTRACTOR care coordinator. When necessary, the CONTRACTOR care coordinator will make an effort to contact the program person of those Enrollees who have medical needs that require such coordination.

c. The CONTRACTOR will coordinate health care needs for Enrollees with Special Health Care Needs with the services of other agencies (e.g., 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.

7. Case Management and Coordination of Care Program

a. The CONTRACTOR will have a basic system 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. The CONTRACTOR's case management (CM) program will 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 CM program will have sufficient resources to meet the needs of the enrolled population and anticipated enrollment as needs change. The CONTRACTOR will use the information the DEPARTMENT provides on Enrollees with Special Health Care Needs to coordinate care and determine case management needs.

b. case management program includes, but is not limited to:

(1) Methods used to identify Enrollees with Special Health Care Needs and Enrollees needing case management or coordination on enrollment and ongoing methods for existing enrollees; e.g. a mechanism to perform health needs assessments upon enrollment for all Enrollees within the time frames required by the contract, to identify Enrollees with Special Health Care needs, to identify Enrollees needing case management services and to help facilitate

care/services in accordance with treatment plans

(2) Methodologies to determine the frequency and duration of CM services through application of established criteria.

(3) Mechanism to refer to and coordinate with other state agencies and community resources as necessary (i.e., coordination of medical and mental health care, transportation, aging services, waiver programs, CSHCN clinics, DSPD, dental, WIC, etc.) when needed.

(4) Assisting with and the monitoring of Enrollees follow up and specialty care (tracking of referrals) to ensure compliance with treatment plan and ensure that members receive recommended follow up and specialty care.

e. Protocols to address Enrollees who are non-compliant.

f. Linkages to the CONTRACTOR's disease management programs.

g. Methods for sharing the results of assessments of Enrollees with Special Health Care Needs in order to prevent duplication of those services and coordinate care. (Efforts to share information will be in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.)

8. Specific Requirements for Children with Special Health Care Needs

a. DEPARTMENT's Identification

The DEPARTMENT will implement mechanisms to identify Children with Special Health Care Needs as defined in this Contract. These identification mechanisms are specified in the DEPARTMENT's Quality Assessment Performance Improvement Plan. (See Attachment D.)

b. Assessment

The CONTRACTOR will implement mechanisms to assess each Child with Special Health Care Needs that the DEPARTMENT has reported to the CONTRACTOR in order to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms will use appropriate health care professionals.

Article V - Delivery Network

A. Availability of Services

1. Appropriate Network

The CONTRACTOR will 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 will consider the following:

a. the anticipated Medicaid enrollment;

b. the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CONTRACTOR's Service Area;

c. the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services; and

d. the number of network providers who are not accepting new Medicaid patients;

e. the geographic locations of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.

2. Direct Access

The CONTRACTOR will 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 preventive 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.)

3. Second Opinion

The CONTRACTOR will 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.

4. Out of Network

If the network is unable to provide Necessary Covered Services under this Contract to a particular Enrollee, the CONTRACTOR will adequately and timely cover these services out of network for the Enrollee, for as long as the CONTRACTOR is unable to provide them. The CONTRACTOR will require out-of-network providers to coordinate with the CONTRACTOR with respect to payment and ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

5. Timely Access

The CONTRACTOR will require that its network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. The CONTRACTOR will ensure that all Covered Serices are available 24 hours a day, 7 days a week, when medically necessary.

6. Timely Access Monitoring

The CONTRACTOR will establish mechanisms to ensure compliance by its network providers and will monitor its providers regularly to determine compliance by providers. If there is failure to comply, the CONTRACTOR will take corrective action.

B. Subcontracts and Assurances

1. General Assurances

Any Covered Service may be subcontracted. The CONTRACTOR will ensure that all subcontracts are in writing and will include any general requirements of this Contract that are appropriate to the service or activity delegated under the subcontract including confidentiality requirements and will assure that all duties of the CONTRACTOR under this Contract are performed. The CONTRACTOR will monitor the subcontractor's performance on an ongoing basis that will be subject to formal review according to a periodic schedule established by the DEPARTMENT, consistent with industry standards. If the CONTRACTOR identifies deficiencies or areas for improvement, the CONTRACTOR and the subcontractor will take corrective action. No subcontract terminates the legal responsibility of the CONTRACTOR to the DEPARTMENT to assure that all activities under this Contract are carried out. The CONTRACTOR will make all subcontracts available upon request.

2. Written Agreement

The CONTRACTOR will oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor. Before any delegation, the CONTRACTOR will evaluate the prospective subcontractor's ability to perform the activities to be delegated. There will be a written agreement between the CONTRACTOR and subcontractor that:

a. specifies the activities and report responsibilities delegated to the subcontractor;

b. includes a provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

c. includes a provision that if the subcontractor becomes insolvent or bankrupt, Enrollees will not be liable for the debt of the subcontractor; and

d. specifies that the subcontractor, acting within the lawful scope of his or her practice, will not be prohibited from advising or advocating on behalf of an Enrollee who is his or her patient 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.

3. Practice Guidelines

a. The CONTRACTOR and its subcontractors will adopt practice guidelines that meet the following requirements:

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

(2) consider the needs of the Enrollees in the CONTRACTOR's health plan;

(3) are adopted in consultation with contracting health care professionals; and

(4) are reviewed and updated periodically as appropriate.

b. The CONTRACTOR will disseminate the practice guidelines to all affected providers and, upon request, to Enrollees and Potential Enrollees.

c. The CONTRACTOR will 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.

4. No Provisions to Reduce or Limit Medically Necessary Services

The CONTRACTOR will ensure that subcontractors abide by the requirements of Section 1128(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.

5. Domestic Violence

The CONTRACTOR will 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.

6. Requirement of 60 Days Written Notice Prior to Termination of Contract

All subcontracts and agreements will include a provision stating that if either party (the subcontractor or CONTRACTOR) wishes to terminate the subcontract or agreement, whichever party initiates the termination will give the other party written notice of termination at least 60 calendar days prior to the effective termination date. The CONTRACTOR will notify the DEPARTMENT of the termination on the same day that the CONTRACTOR either initiates termination or receives the notice of termination from the subcontractor.

7. Compliance with CONTRACTOR's Quality Assurance Plan

All of the CONTRACTOR's providers will be aware of the CONTRACTOR's Quality Assurance Plan and activities. All subcontracts with the CONTRACTOR will include a requirement securing cooperation with the CONTRACTOR's Quality Assurance Plan and activities and will allow the CONTRACTOR access to the subcontractor's medical records of its Enrollees.

8. Unique Identifier Required

All physicians who provide services under this Contract will 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.

9. Payment of Provider Claims

a. The CONTRACTOR will 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 regulation at 42 CFR 447.45 and 447.46, unless the CONTRACTOR and its provider establish an alternative payment schedule. A claim means: 1) a bill for services, 2) a line item of services, or 3) all services for one Enrollee within a bill.

b. "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 DEPARTMENT'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. The CONTRACTOR will pay 90 percent <u>of all clean</u> claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of receipt.

c. The date receipt is the date the CONTRACTOR receives the claim, as

indicated by its date stamp on the claim, and the date of payment is the date of the check or other form of payment.

C. CONTRACTOR's Selection of Providers

1. Credentialing and Recredentialing of Providers

The CONTRACTOR will maintain written policies and procedures for selection and retention of providers. The CONTRACTOR will establish and follow a documented credentialing and recredentialing process for providers who have signed contracts or participation agreements to: (1) assure that clinical staff are appropriately credentialed, e.g. that the individual has a current license, is in good standing with licensing boards, etc., and (2) review records for any adverse actions or sanctioning of CONTRACTOR's staff by other states or the federal government.

2. No Discrimination

a. The CONTRACTOR's subcontractor selection policies and procedures cannot discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment.

b. The CONTRACTOR will not discriminate against subcontracting 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 requires the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its Enrollees; nor does it preclude the CONTRACTOR from using different reimbursement amounts for different specialities or for different practitioners in the same speciality; nor does it preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

c. If the CONTRACTOR declines to include individual or groups of providers in its network, it will give the affected providers written notice of the reason for its decision.

3. Ownership or Controlling Interest - Disclosure to the DEPARTMENT

The CONTRACTOR will notify the DEPARTMENT of any person or corporation that has five percent or more ownership or controlling interest in the entity.

4. Excluded Entities and Providers

a. The CONTRACTOR will not employ or subcontract with any individual who is under a current federal debarment, suspension, sanction or exclusion from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act (the Act), or who has had his or

her license suspended or revoked by any state.

b. The CONTRACTOR may not knowingly have a relationship described in 4.c. with the following:

(1) an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No.12549; or

(2) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in 4.b(1).

c. The CONTRACTOR will not knowingly have a relationship of the following types with individuals identified in 4.b. above:

(1) a director, officer, or partner of the CONTRACTOR;

(2) a person with beneficial ownership of five percent or more of the CONTRACTOR's equity;

(3) a person with an employment, consulting or other arrangement with the CONTRACTOR for the provision of items and services that are significant and material to the CONTRACTOR's obligations under this Contract with the DEPARTMENT.

d. Effect of Non-Compliance – If the DEPARTMENT finds that the CONTRACTOR is not in compliance with these requirements, the DEPARTMENT will notify the Secretary of the Department of Health and Human Services of the noncompliance.

(1) The DEPARTMENT may continue the Contract with the CONTRACTOR unless the Secretary directs otherwise.

(2) The DEPARTMENT may not renew or otherwise extend the duration of an existing Contract with the CONTRACTOR unless the Secretary provides to the DEPARTMENT and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract.

5. Federally Qualified Health Centers (FQHCs)

If the CONTRACTOR enters into a subcontract with a Federally Qualified Health Center (FQHC), the CONTRACTOR will reimburse the FQHC an amount not less than what the CONTRACTOR pays comparable providers that are not FQHCs.

Article VI - Authorization of Services and Notices of Action

F. Service Authorization and Notice of Action

1. Policies and Procedures for Service Authorizations

The CONTRACTOR will establish and follow written policies and procedure for processing requests for initial and continuing authorization of Covered Services.

a. The CONTRACTOR will implement mechanisms to ensure consistent application of review criteria for service authorization decisions and consult with the requesting provider when appropriate.

b. The CONTRACTOR will 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.

c. The CONTRACTOR will 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. (See Section III, Content of Notice of Action, below.)

2. Process for the CONTRACTOR to Request Payment Authorization of Services

Since this is a Non-risk Contract, the total payments the DEPARTMENT reimburses the CONTRACTOR may not exceed the upper limit payments specified in 447.362 and may be reimbursed by the State at the end of the Contract period based on the CONTRACTOR's incurred costs. The payment authorization process is to ensure services will be included in the CONTRACTOR's incurred costs and in the upper payment limit when the DEPARTMENT determines whether payments it made to the CONTRACTOR are more or less than the upper payment limit.

This process also ensures the CONTRACTOR is appropriately applying practice guidelines, making utilization management decisions and is covering services for Enrollees requiring special consideration based on their special needs.

a. The CONTRACTOR may submit a request for payment of services to the Bureau of Managed Health Care. The BMHC will review payment requests when:

(1) Medicaid does not have criteria, criteria is not clearly defined, criteria does not address the unique medical condition, or a procedure is a newly approved FDA procedure. Examples are:

(a) Medicaid does not have criteria and it is a unique condition – in order to save the life of a pregnant mother and acardiac twin, patient needs highly specialized procedure only performed at an out-of-state center of excellence; and

(b) new FDA-approved technology – magnetoencephalography is used to diagnose and assist neurosurgeons when performing corrective brain surgery for refractory epilepsy and gliomas.

(2) the service is beyond the limits of the covered benefit, but is medically necessary and is in lieu of more costly services. Examples are:

(a) in order to prevent hospitalization, additional home health or physical therapy services are necessary;

(b) in order to prevent infections leading to a hospitalization, patient's condition requires more tracheostomy supplies than what Medicaid typically covers;

(c) patient requires more insulin pump reservoirs than Medicaid typically covers based on the type and amount of insulin patient uses.

b. The CONTRACTOR submits the necessary information to a BMHC nurse for review. The CONTRACTOR must include the following information in a written request outlining:

(1) the services the CONTRACTOR is asking the BMHC to review;

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

(3) Medicaid's fee-for-service policy governing the service;

(4) information documenting medical necessity;

(5) a copy of the practice guideline or medical pathway the CONTRACTOR used to review the case;

(6) a cost/benefit analysis with an outline of any alternative solutions and associated costs;

(7) the short term and long term plan for the service and Enrollee;

(8) verification that the CONTRACTOR's medical director has reviewed the case (including his/her recommendations); and

(9) any additional pertinent documentation the CONTRACTOR feels is necessary for the BMHC's review.

c. Once the BMHC has all necessary information, a BMHC nurse reviews the request for approval or denial of payment. The BMHC nurse may consult with medical and non-medical DEPARTMENT staff to verify the

appropriate interpretation of Medicaid coverage. The BMHC nurse makes a recommendation to a physician consultant who then reviews the request for approval or denial based on medical necessity. Appropriate DEPARTMENT staff reviews high cost requests before they are authorized for payment. Once the DEPARTMENT has determined whether the request is authorized for payment, the BMHC nurse notifies the CONTRACTOR of the decision. The BMHC and CONTRACTOR track all requests.

3. Time Frames for Service Authorization Decisions

The CONTRACTOR will adhere to the following time frames for making service authorization decisions and mailing Notices of Action to Enrollees and providers:

a. **Standard Service Authorization Approvals**

(1) The CONTRACTOR will 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 receipt of the request for Service Authorization.

(2) Extensions— The CONTRACTOR may extend the time frame for making the decision by up to 14 additional calendar days if:

(a) the Enrollee or the provider requests 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. **Standard Service Authorization Decisions to Deny or Authorize Less Than Requested and Notice of Action**

(1) 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 will make the decision and give a Notice of Action to the Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the request for Service Authorization.

2) The CONTRACTOR will also notify the requesting provider, although the notice need not be in writing.

(3) Extensions— The CONTRACTOR may extend the time frame for making the decision by up to 14 additional calendar days if:

(a) the Enrollee or the provider requests 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.

c. ***Extension of Time Frames for Standard Service Authorization Decisions***

If the CONTRACTOR extends the time frame for making standard Service Authorization decisions in accordance with Section A.2 a. and A.2.b. above, the CONTRACTOR will:

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

(2) inform the Enrollee of his or her right to file a Grievance, and how to do so, if the Enrollee disagrees with that decision (See Article VII, Grievance System, Section I., Grievances); and

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

d. ***Expedited Service Authorization Decisions***

(1) For cases in which a provider indicates, or the CONTRACTOR determines (on a request from an Enrollee), that following the standard time frame above could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR will 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 receipt of the request for Service Authorization.

2) The CONTRACTOR will follow notification requirements outlined in 2. a. and 2.b. above.

(3) Extensions– The CONTRACTOR may extend the three working-day time period by up to 14 calendar days if:

(a) the Enrollee requests an 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.

e. ***Service Authorization Decisions Not Reached Within Required Time Frames***

For Service Authorization decisions not reached within the time frames specified in paragraphs 2.a, 2.b. and 2.d above, which constitutes a denial and is thus an adverse Action, the CONTRACTOR will give a Notice of Action on the date that the time frame expires.

f. Decisions to Terminate, Suspend or Reduce Previously Authorized Medicaid-Covered Services

If the CONTRACTOR terminates, suspends or reduces previously authorized Medicaid-covered services, and the Enrollee informs the CONTRACTOR that he or she disagrees with the change in his or her treatment plan, this constitutes an Action. The CONTRACTOR will 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 before the date of the Action; or

(2) 5 days before the date of the Action if the CONTRACTOR has facts indicating that Action should be taken because of probable fraud by theEnrollee, and the facts have been verified, if possible, through secondary sources; or

(3) by the date of the Action if:

(a) the CONTRACTOR has factual information confirming the death of the Enrollee;

(b) the CONTRACTOR receives a clear written statement signed by the Enrollee that:

(i) he no longer wishes services; or

(ii) he gives information that requires termination or reduction of services and indicates that he understands that this will be the result of supplying that information;

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

(d) 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 will be reinstated if his whereabouts become known during the time is eligible for services;

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

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

B. Other Actions Requiring Notice of Action

1. Action to Deny Payment in Whole or Part for a Service

a. The CONTRACTOR will notify the requesting provider of decisions to deny payment in whole or in part.

b. The CONTRACTOR will also mail the Enrollee a written Notice of Action at the time of the Action affecting a claim, if the denial reason is that (1) the service was not authorized by the CONTRACTOR, as the Enrollee could be liable for payment if the Enrollee gave advance written consent to the provider that he or she would pay for the specific service; (2) the Enrollee requested continued benefits (services) during an Appeal or State fair hearing and the appeal or State fair hearing decision was adverse to the Enrollee, or (3) the Enrollee was not eligible for Medicaid when the service was provided.

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; or

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

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

2. Action Due to Failure to Provide Covered Services in a Timely Manner

Failure of the CONTRACTOR's subcontractors to provide services in a timely manner constitutes an Action. The CONTRACTOR will 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 as defined in Article IX - Contractor Assurances, Section E - Access, Subsection 4.e. - Waiting Time Benchmarks.

3. Action Due to Failure to Resolve Appeals and Grievances Within Required Time Frames

a. Failure of the CONTRACTOR to act within the time frames provided for resolving and giving resolution notice for Appeals or Grievances constitutes an Action. The CONTRACTOR will provide a Notice of Action to the Enrollee at the time the CONTRACTOR determines the time frame for resolving the Appeal or the Grievance will not be met. (See Article VII, Grievance Systems.)

b. If the CONTRACTOR does not resolve an Appeal within the required time frame, the Enrollee has already gone through the CONTRACTOR's appeal process. Therefore, by declaring the CONTRACTOR's failure to provide resolution of the Appeal within the required time frame an Action, the Enrollee may now file a request for a State fair hearing as the Enrollee has

already exhausted the CONTRACTOR's internal appeals process. The Enrollee need not go through the CONTRACTOR's internal appeals process again.

c. For Notice of Action due to failure to resolve an Appeal within the required time frame, the CONTRACTOR will include in the Notice of Action the information specified in Article VII, Grievance System, Section C., #5, Format and Content of Notice of Appeal Resolution, regarding procedures and time frames for filing a request for a State fair hearing (rather than information on filing an Appeal). The CONTRACTOR will also attach to the Notice of Action a copy of the "Request for a Hearing/Agency Action" form that the Enrollee will submit to request a State fair hearing.

C. Content of Notice of Action

1. The CONTRACTOR's Notice of Action to the Enrollee will be in writing and meet the language and format requirements outlined in Article III (Marketing ...), Section D (Member Services), Subsection 1 (Enrollee Information Requirements), to ensure ease of understanding. The notice to the provider need not be in writing.

2. The written Notice of Action will explain the following:

a. the Action the CONTRACTOR has taken or intends to take;

b. the reason for the Action;

c. the date the Action will become effective when the Action is to terminate, suspend, or reduce a previously authorized Covered Service (see Section A.2. f., of this Article);

d. the Enrollee's or the provider's right to file an Appeal of the Action with the CONTRACTOR and that providers may file an Appeal for the Enrollee only with the Enrollee's written consent (see Article VII, Grievance System, Section C. Standard Appeals Process, #1, Authority to File, item b.);

e. the procedures for filing an Appeal (See Article VII, Grievance System, Section C. Standard Appeals Process, and Section D., Process for Expedited Resolution of Appeals);

f. the circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution (see Article VII, Grievance System, Section D., Process for Expedited Resolution of Appeals);

g. the Enrollee's right to have benefits 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;

h. how to request that benefits 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 which is based on federal regulation in 42 CFR 438.420; and (438.404(b)(7), and 438.420(d).

i. the time frames for filing an Appeal:

(1) If the Enrollee is **not** requesting continuation of benefits 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 with the Enrollee's written consent, will file the Appeal within 30 days from the date on the CONTRACTOR's Notice of Action; or

2) If the Enrollee is requesting continuation of benefits 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 will 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.

Also see Article VII, Grievance Systems, Section C., Standard Appeals Process, #2., Timing, and #3, Procedures, item b., and Section E., Continuation of Benefits During the Appeal or State Fair Hearing Process.

D. Attachment to Notice of Action - Written Appeal Request Form

1. ***General Requirements***

The CONTRACTOR will 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. This form may also be used for expedited Appeal requests if the Enrollee chooses to submit a written request for an expedited Appeal resolution, even though an oral request is all that is required. (See Article VI, Section D., 2.)

The CONTRACTOR will not include this attachment if the Notice of Action is due to the circumstances in Section B. 3. above. For the Action specified in Section B.3. above, the CONTRACTOR will provide a Notice of Action that informs Enrollees of their State fair hearing rights and how to request a State fair hearing.

2. Specific Content of Written Appeal Request Form

The form will:

a. provide a prompt (through use of check boxes or other means) for Enrollees to:

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

(2) request continuation of benefits, if applicable;

b. provide a statement that if continuation of benefits 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;

c. summarize assistance the Enrollee may request to complete the Appeal Request form and how to request the assistance (see Article VII, Grievance System, Section C., Standard Appeals Process, #3 Procedures, item e.); and

d. 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 will be followed by a written Appeal request within five working days from the date of the oral filing. (See Article VII, Grievance System, Section C., Standard Appeals Process, #3., Procedures, item b.)

E. Compensation for Utilization Management Activities

The CONTRACTOR will 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.

F. Medical Necessity Denials

When the CONTRACTOR determines that a service will not be covered due to the lack of medical necessity, the CONTRACTOR will send all documentation supporting their decision to the DEPARTMENT for its review before the CONTRACTOR's determination is deemed final, when the following conditions are met:

4. there are no established national standards for determining medical necessity, and

2. the DEPARTMENT does not have medical necessity criteria for the service.

The DEPARTMENT will review the documentation and determine what the DEPARTMENT's decision would be regarding coverage for the service. The DEPARTMENT and the CONTRACTOR will work collaboratively in making a final decision on whether the service is to be covered by the CONTRACTOR.

Article VII - Grievance Systems

C. Overall Grievance System

The CONTRACTOR will 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 (see Article I, Definitions, definition of Action), and (3) procedures for an Enrollee, or a provider acting on behalf of an Enrollee, to access the State's fair hearing system.

D. Special Requirements for Appeals

The CONTRACTOR's process for appeals will:

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 will 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. (see Section C. regarding expedited resolution of Appeals, and Section C., item #3.b., below.);

3. provide the Enrollee reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CONTRACTOR will 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 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:

   a. include as parties to the Appeal the Enrollee and his or her representative, or

   b. the legal representative of a deceased Enrollee's estate.

C. Standard Appeals Process

1. Authority to File

a. An Enrollee or his or her legally authorized representative may file an Appeal; or

b. A provider, acting on behalf of the Enrollee and with the Enrollee's written consent, may file an Appeal.

2. Timing

c. The Enrollee or provider may file an Appeal of a Notice of Action within 30 calendar days from the date on the CONTRACTOR's Notice of Action (See Article VI, Authorization of Services and Notices 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 want benefits to continue during the Appeal process, then the Enrollee will 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.
   (See Section E. of this Article, Continuation of Benefits During the Appeal or State Fair Hearing Process.)

3. Procedures

a. The Enrollee or the provider may file an Appeal either orally or in writing.

b. Unless the Enrollee or provider requests an expedited resolution of the Appeal (which does not require a written follow-up request), the oral Appeal will be followed with a written, signed Appeal. The written, signed Appeal will be received within five working days from the date of the oral Appeal. (See Section D regarding expedited Appeal resolutions.)

c. A provider may file the written, signed Appeal on behalf of the Enrollee and will include the Enrollee's signed written consent.

d. If an Enrollee or provider requests an Appeal orally, the CONTRACTOR will inform or remind the Enrollee or provider of the following:

(1) that the oral filing of an Appeal will be followed with a written, signed appeal within five working days from the date of the oral Appeal;

(2) if applicable, that the provider can file an Appeal only with the Enrollee's attached written consent;

(3) of the standardized form that can be used to submit the Appeal in writing;

(4) that if the Enrollee wants continuation of benefits when the Action is to terminate, suspend or reduce a previously authorized course of treatment, that this will be requested; and

(5) to whom or where to send the written, signed Appeal.

e. The CONTRACTOR will 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 capability.

f. The CONTRACTOR will acknowledge receipt of the Appeal either orally or in writing and explain to the Enrollee the process that will be followed to resolve the Appeal.

g. As per Section B. 3. of this Article, provide the Enrollee reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CONTRACTOR will inform the Enrollee of the limited time available for this in the case of an expedited Appeal resolution.

h. As per Section B.4. of this Article, provide the Enrollee and his or her authorized representative 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:

(1) include as parties to the Appeal the Enrollee and his or her representative, or

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

i. The CONTRACTOR will 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) who, 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:

(1) an Appeal of a denial that is based on lack of medical necessity; or

(2) an Appeal that involves clinical issues.

4. Time Frames for Appeal Resolution and Notification

a. The CONTRACTOR will 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 Appeal whether orally or in writing.

b. Extension of Time Frame – 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 time frame, and the extension was not requested by the Enrollee, the CONTRACTOR will give the Enrollee written notice of the reason for the delay.

5. Format and Content of Notice of Appeal Resolution

The CONTRACTOR will provide a written Notice of Appeal Resolution to the affected parties. The written Notice of Appeal Resolution will include the following:

a. the results of the Appeal resolution process and the date it was completed; and

b. for Appeals not resolved wholly in favor of the Enrollee, the CONTRACTOR will include the following in the written Notice of Appeal Resolution:

(1) the right to request a State fair hearing and how to do so;

(2) the right to request continuation of benefits 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 benefits;

(4) a statement that the Enrollee may be liable for the cost of 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 benefits is not requested and when continuation of benefits is requested (see Section F, Duration of Continued or Reinstated Benefits, #2, and Section H, State Fair Hearings, #1 and #2, of this Article); and

(6) a copy of either: (a) the "Request for a Standard Sate Fair Hearing/Agency Action" form or (b) the "Request for an Expedited State Fair Hearing/Agency Action form that the Enrollee must complete and submit to the DHCF to request a State fair hearing, and continuation of benefits, if applicable. The CONTRACTOR will include a copy of the "Request for an Expedited State Fair Hearing/Agency Action" form if the Enrollee had an expedited Appeal.

(See Section E., Continuation of Benefits During the Appeal or State Fair Hearing Process, Section F., Duration of Continued or Reinstated Benefits, and Section H., State Fair Hearings, of this Article, for additional information on all of the above.)

D. Process for Expedited Resolution of Appeals

1. General Requirements

The CONTRACTOR will establish and maintain an expedited review process for Appeals, when the CONTRACTOR determines (from a request from the Enrollee) or a provider indicates (in making the Appeal request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

2. Authority to File

The Enrollee, or a provider with the Enrollee's written consent, may file an expedited Appeal request either orally or in writing.

3. Timing

a. The Enrollee or provider may file an Appeal of a Notice of Action within 30 days from the date on the CONTRACTOR's Notice of Action (See Article VI, Authorization of Services and Notices 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 want benefits to continue during the Appeal process, then the Enrollee will 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.
(See Section E. of this Article, Continuation of Benefits During the Appeal or State Fair Hearing Process.)

4. Procedures

a. When an Enrollee or provider requests an expedited resolution of an Appeal, the CONTRACTOR will inform the Enrollee or provider of the limited timeavailable for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

b. The CONTRACTOR will 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 will give Enrollees any reasonable assistance in taking 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.

d. The CONTRACTOR will acknowledge receipt of the request for expedited Appeal resolution either orally or in writing and explain to the Enrollee the process that will be followed to resolve the Appeal;

e. The CONTRACTOR will 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) who, 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:

(1) an Appeal of a denial that is based on lack of medical necessity; or

(2) an Appeal that involves clinical issues;

f. Denial of a Request for Expedited Appeal Resolution– If the CONTRACTOR denies a request for an expedited resolution of an Appeal, the CONTRACTOR will:

(1) transfer the Appeal to 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; and

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

5. Time Frame for Expedited Appeal Resolution and Notification

a. The CONTRACTOR will 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. Extension of Time Frame– 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).

(3) If the CONTRACTOR extends the time frame, and the extension was not requested by the Enrollee, the CONTRACTOR will give the Enrollee written notice of the reason for the delay.

6. Format and Content of Expedited Appeal Resolution Notice

a. The CONTRACTOR will make reasonable effort to provide oral notice of the expedited resolution in addition to providing a written Notice of Appeal Resolution.

b. The CONTRACTOR will provide a written Notice of Appeal Resolution that meets the same format and content requirements outlined in Section C.,

Standard Appeals Resolution, #5., Format and Content of Notice of Appeal Resolution.

E. Continuation of Benefits During Appeal or State Fair Hearing Processes

The CONTRACTOR will continue the Enrollee's benefits during the 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 files the Appeal timely, which means filing the Appeal on or before the later of the following:

a. within 10 days of the Notice of Action; or

b. the intended effective date of the CONTRACTOR's proposed Action; and

5. the Enrollee requests extension of benefits in the Appeal.

F. Duration of Continued or Reinstated Benefits

If the CONTRACTOR continues or reinstates the Enrollee's benefits, the CONTRACTOR will continue benefits until one of the following occurs:

5. the Enrollee withdraws the Appeal;

2. 10 days pass after the CONTRACTOR mails the written Notice of Appeal Resolution and within that 10-day time period, the Enrollee does not request a State fair hearing with continuation of benefits 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 or service limits of a previously authorized service has been met.

G. Reversed Appeal Resolutions

1. Services Not Furnished While the Appeal is Pending

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 will authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.

2. Services Furnished While the Appeal is Pending

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 will pay for those services in accordance with State policy and regulations.

H. State Fair Hearings

When the Enrollee or provider has exhausted the CONTRACTOR's Appeal decision and a final decision has been made, the CONTRACTOR will provide written notification to the party who initiated the Appeal of the outcome and explain in clear terms a detailed reason for the denial.

The CONTRACTOR will provide notification to Enrollees and providers that the final decision of the CONTRACTOR may be appealed to the DEPARTMENT and will give to the Enrollee and provider the DEPARTMENT's form to request a State fair hearing. The Health Plan will inform the Enrollee and provider the time frame for requesting a State fair hearing.

1. The DEPARTMENT will permit Enrollees and providers, acting as an Enrollee's authorized representative, to request a State fair hearing within 30 days from the date of the CONTRACTOR's Notice of Appeal Resolution.

2. However, if the Enrollee wants to continue benefits pending the outcome of the State fair hearing, when a previously authorized course of treatment has been terminated, suspended or reduced, 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 benefits will be submitted within 10 days after the CONTRACTOR mails the Notice of Appeal Resolution. (See Section E., Duration of Continued or Reinstated Benefits, above.)

3. The parties to the State fair hearing include the CONTRACTOR as well as the Enrollee and his or her representative which may include legal counsel, a relative, a friend or other spokesman, or the representative of a deceased Enrollee's estate.

4. The Enrollee or his or her representative, will 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.

5. The Enrollee will also be given the opportunity to:

a. bring witnesses;

a. establish all pertinent facts and circumstances;

b. present an argument without undue interference; and

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

6. 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 and are in

the Enrollee's or provider's favor. Any decision made by the DEPARTMENT pursuant to the hearing will be subject to appeal rights as provided by State and Federal laws and rules.

7. The Enrollee will be notified in writing of the State fair hearing decision and any appeal rights as provided by State and Federal laws and rules.

8. Standard resolution requests– The DEPARTMENT will reach its hearing decision within 90 (calendar) days from the date the Enrollee filed the Appeal with the CONTRACTOR.

9. Expedited Appeal resolution requests – The DEPARTMENT will reach its hearing decision within three working days from the date the DEPARTMENT receives a State fair hearing request for a denial of a service that:

a. meets the criteria for the expedited appeal process but was not resolved using the CONTRACTOR's required expedited Appeal time frames; or

b. was resolved wholly or partially adversely to the Enrollee using the CONTRACTOR's expedited Appeal time frames.

I. Grievances

1. Authority to File

b. An Enrollee may file a Grievance; or

b. A provider, acting on behalf of the Enrollee as an authorized representative, may file a Grievance.

2. Procedures

a. The Enrollee or the provider may file a Grievance either orally or in writing.

b. The CONTRACTOR will 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 will acknowledge receipt of the Grievance either orally or in writing.

d. The CONTRACTOR will ensure that the individuals who make the decision on a Grievance are individuals who (1) were not involved in any previous

level of review or decision-making, if applicable to the nature of the Grievance and (2) who, 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:

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

(2) a Grievance that involves clinical issues.

3. Time Frames for Grievance Disposition and Notification

a. The CONTRACTOR will 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 will notify the affected parties in writing of the disposition of the Grievance. For Grievances received orally, the CONTRACTOR will notify the affected parties of the disposition either orally or in writing.

c. If the Enrollee, or a provider on behalf of an Enrollee, files a Grievance with the DEPARTMENT, the DEPARTMENT will apprize the Enrollee, or the provider on behalf of the Enrollee, 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 will promptly notify the CONTRACTOR both orally and in writing of the Enrollee's Grievance in his or her behalf.

2) The CONTRACTOR will follow the procedures and time frames outlined above for Grievances.

3) The CONTRACTOR will notifying the affected parties, including the DEPARTMENT, in writing of the disposition of the grievance.

d. Extension of Time Frame – The CONTRACTOR may extend the time frame 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).

(3) If the CONTRACTOR extends the time frame, and the extension was not requested by the Enrollee, the CONTRACTOR will give the Enrollee written notice of the reason for the delay.

J. Documentation

The CONTRACTOR will maintain complete records of all Appeals and Grievances and submit semi-annual reports summarizing Appeals and Grievances using DEPARTMENT-specified reporting templates. The CONTRACTOR will separately track Grievances and Appeals that are related to Children with Special Health Care Needs and those related to Non-Traditional Medicaid Enrollees. (See Article XIII, Records and Reporting Requirements, C.3.c.)

1. Appeals

The CONTRACTOR will maintain documentation including but not limited to:

a. written Notices of Action;

b. a log of all oral Appeals and oral requests for expedited resolution of Appeals, including:

(1) date of the oral requests;

(2) date of acknowledgment of oral requests for expedited resolution of Appeals and method of acknowledgment (i.e., orally or in writing);

(3) date of denials of requests for expedited Appeal resolution; and

4) date of attempt to give prompt oral notice;

c. copies of written standard Appeal requests;

d. copies of written notices of denial of requests for expedited Appeal resolution;

e. date of acknowledgment of written standard Appeal requests and method of acknowledgment (i.e., orally or in writing);

f. copies of written notices when extending the time frame for adjudicating standard or expedited Appeals when the CONTRACTOR initiates the extension;

g. copies of written Notices of Appeal Resolution; and

h. any other pertinent documentation needed to maintain a complete record of all Appeals and to demonstrate that Appeals were adjudicated according to the Contract provisions governing Appeals.

2. Grievances

a. Oral Grievances - Using its previously established verbal complaint logging and tracking system, the CONTRACTOR will log all oral Grievances and include the following:

(1) date the Grievance was received;

(2) date and method of acknowledgment (i.e., orally or in writing);

(3) name of 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 will maintain a copy of the written notification.

b. Written Grievances - The CONTRACTOR will maintain all written Grievances and copies of the written notices of resolution to the affected parties.

Article VIII - Enrollee Rights and Protections

A. Written Information on Enrollee Rights and Protections - General Requirements

1. The CONTRACTOR will develop and maintain written policies regarding Enrollee rights and protections.

2. The CONTRACTOR will comply with any applicable Federal and State laws that pertain to Enrollee rights and ensure that its staff and subcontracting providers take those rights into account when furnishing services to Enrollees.

3. The CONTRACTOR will ensure information on Enrollee rights and protections is provided to all Enrollees by including its Patient Rights statement in its member handbook. (See Article III, Marketing ...., Section D, Member Education, 2.o.)

4. The CONTRACTOR will ensure Enrollees are free to exercise their rights, and that the exercise of those rights will not adversely affect the way the CONTRACTOR and its subcontractors treat Enrollees.

B. Specific Enrollee Rights and Protections

The CONTRACTOR will 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, sections 164.524 and 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 will not be adversely treated by the CONTRACTOR and its providers.

C. Provider - Enrollee Communications

1. General Rules

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

a. the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. any information the Enrollee needs in order to decide among all relevant treatment options;

c. the risks, benefits, and consequences of treatment or non-treatment; and

d. 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.

2. Objection to Services on Moral or Religious Grounds

Subject to the information requirements below, if the CONTRACTOR that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in C.1 in this section, 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 will

a. 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

b. 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 IX - Contractor Assurances

A. Nondiscrimination

The CONTRACTOR will designate a nondiscrimination coordinator who will 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. 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. The CONTRACTOR will 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.

B. Member Services Function

The CONTRACTOR will operate a Member Services function during regular business hours. Ongoing training, as necessary, will be provided by the CONTRACTOR to ensure that the Member Services staff is conversant in the CONTRACTOR's policies and procedures as they relate to Enrollees. At a minimum, Member Services staff will be responsible for the following:

1. Explaining the CONTRACTOR's rules for obtaining services;

2. Assisting Enrollees to select or change primary care providers;

3. Fielding and responding to Enrollee questions and the Grievance System.

The CONTRACTOR will 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.

C. Provider Services Function

The CONTRACTOR will operate a Provider Services function during regular business hours. At a minimum, Provider Services staff will be responsible for the following:

1. Training, including ongoing training, of the CONTRACTOR's providers on Medicaid rules and regulations that will 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 authorization and referral protocols;

4. Assisting providers with claims payment procedures;

5. Fielding and responding to provider questions and the Grievance System.

D. Enrollee Liability

The CONTRACTOR will 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 has not 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 arrangement with the CONTRACTOR that are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from the CONTRACTOR.

E. Access

1. Basic Rule

   The CONTRACTOR will provide the DEPARTMENT adequate assurances and supporting documentation that demonstrates the CONTRACTOR has the capacity to serve the expected enrollment in its Service Area in accordance with the DEPARTMENT's standards for access to care.

2. Nature of Supporting Documentation

   The CONTRACTOR will provide the DEPARTMENT documentation, in a format specified by the DEPARTMENT that the CONTRACTOR offers an appropriate range of preventive, primary care and speciality 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.

3. Timing of Documentation

The CONTRACTOR will submit to the DEPARTMENT the documentation assuring adequate capacity and services in the DEPARTMENT-specified format no less frequently than:

a. at the time it enters into a contract with the DEPARTMENT;

b. 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.

4. Specific Provisions

a. Elimination of Access Problems Caused by Geographic, Cultural and Language Barriers and Physical Disabilities

The CONTRACTOR will minimize, with a goal to eliminate, Enrollee's access problems due to geographic, cultural and language barriers, and physical disabilities. The CONTRACTOR will provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. The CONTRACTOR will 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. The CONTRACTOR will accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990 (ADA), as amended. If the CONTRACTOR's facilities are not accessible to Enrollees with physical disabilities, the CONTRACTOR will provide services in other accessible locations.

b. Interpretive Services

The CONTRACTOR will 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 will extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the CONTRACTOR and CONTRACTOR's providers and receive Covered Services. Professional interpreters will 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. Cultural Competence Requirements

The CONTRACTOR will participate in the DEPARTMENT's efforts to promote

the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CONTRACTOR will 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. The CONTRACTOR will 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. The CONTRACTOR will strive to ensure its providers provide culturally sensitive services to Enrollees. These services will 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.

d. No Restrictions of Provider's Ability to Advise and Counsel

The CONTRACTOR may not restrict a health care provider's ability to advise and counsel Enrollees about Medically Necessary treatment options. All contracting providers acting within his or her scope of practice, will 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.

e. Waiting Time Benchmarks

The CONTRACTOR will adopt benchmarks for waiting times for physician appointments as follows:

Waiting Time for Appointments

(1) Primary Care Providers:

(a) within 30 days for routine, non-urgent appointments

(b) within 60 days for school physicals

(c) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)

(2) Specialists:

(a) within 30 days for non-urgent care

(b) within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

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.

F. Coordination and Continuity of Care

1. In General

The CONTRACTOR will ensure access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities. The CONTRACTOR will 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. The CONTRACTOR will 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. The CONTRACTOR's providers are not responsible for rendering Home and Community-Based Waiver services.

2. Primary Care

a. The CONTRACTOR will implement procedures to deliver primary care to and coordinate health care services for all Enrollees. The CONTRACTOR will 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.

b. The CONTRACTOR will allow Enrollees the opportunity to select a participating Primary Care Provider. This excludes clients who are under the Restriction Program. If an Enrollee's Primary Care Provider ceases to participate in the CONTRACTOR's network, the CONTRACTOR will offer the Enrollee the opportunity to select a new Primary Care Provider.

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 will share appropriate information regarding the Enrollee's health care to ensure coordination of physical and mental health care services.

b. The CONTRACTOR will educate its subcontracted providers regarding an effective model of coordination such as the model developed by the PMHP/Health Plan Coordination of Care Committee. The CONTRACTOR will ensure its subcontracted providers coordinate the provision of physical health care services with mental health care services as appropriate.

a. When an Enrollee is also enrolled in a Prepaid Mental Health Plan, the CONTRACTOR will 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. As described in Attachment B, IV (Benefits), Section E (Clarification of Covered Services), Subsection 8 of this Contract, the independent panel established by the DEPARTMENT will assist in adjudicating such disputes when requested to do so by either party.

b. 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, will have access to such services in a timely fashion. The CONTRACTOR and Prepaid Mental Health Plan will reduce or eliminate unnecessary barriers that may delay the Enrollee's access to these critical services.

4. Restriction Program

a. The CONTRACTOR will provide care coordination for its Restricted Enrollees. The CONTRACTOR will provide staff who will 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 request, or other questions or problems. The CONTRACTOR will 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 (PCP). Review and update as needed. When a personalized care plan is developed, submit copies to the DEPARTMENT

to be included in the Enrollee's Restriction case file;

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

(5) Provide information to the DEPARTMENT's Restriction staff that will help assess Restriction Enrollees' progress and that may include periodic written or telephonic evaluations when requested by the Restriction staff;

(6) Ensure a single point of contact for restricted members to allow effective care coordination by the CONTRACTOR staff. The CONTRACTOR is authorized to accept, approve or forward the following to the DEPARTMENT's Restriction Program staff:

(a) Accept and forward requests for overrides on pharmacy

claims according to DUR regulations (i.e. cumulative, early refill, non-covered, non-concurrent policies, etc.) to the DEPARTMENT.

(b) Accept and approve PCP changes according to program guidelines; contact the PCP for affirmation of his/her acceptance on each individual enrollee prior to approving them as an Enrollee's PCP; and coordinate changes with the Restriction Program staff.

(c) Accept and forward pharmacy change requests to the DEPARTMENT's Restriction staff and coordinate changes with the Restriction Program staff.

b. The CONTRACTOR will 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 will agree to the following:

(1) manage all of the Enrollee's medical care;

(2) educate the Enrollee regarding 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) will 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

(8) provide information to the DEPARTMENT's Restriction staff that will help assess Restriction Enrollees' progress and that may include periodic written or telephonic evaluations when requested by the Restriction staff.

c. If the Restricted Enrollee's PCP chooses to no longer serve as the Enrollee's PCP, the CONTRACTOR will assist the Enrollee in finding a new PCP and

coordinate with the DEPARTMENT's Restriction staff.

d. If a Restriction PCP ceases participation with the CONTRACTOR, the CONTRACTOR will communicate this immediately to the DEPARTMENT's Restriction staff. The CONTRACTOR will assist all affected Enrollees in finding a new PCP and notify the DEPARTMENT when the new PCP is selected.

G. Billing Enrollees

1. In General

Except as provided in this Article IX, Section G,, Subsection 2, no claim for payment will 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. When a provider accepts an Enrollee as a patient he or she will 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.

2. Circumstances When an Enrollee May be Billed

An Enrollee may in certain circumstances be billed by the provider for non-Covered Services and/or for unpaid Medicaid co-payments or Medicaid co-insurance. A non-Covered Service is one that is not covered under this Contract, or includes special features or characteristics that are desired by the Enrollee, such as more expensive eyeglass frames, hearing aids, custom wheelchairs, etc., but do not meet the Medical Necessity criteria for amount, duration, and scope as set forth in the Utah State Plan or is not authorized by the CONTRACTOR. The DEPARTMENT will specify to the CONTRACTOR the extent of Covered Services and items under the Contract, as well as services not covered under the Contract but provided by Medicaid on a fee-for-service basis that would effect the CONTRACTOR's Covered Services. An Enrollee may be billed for a service not covered under this Contract and/or for unpaid Medicaid co-payment or co-insurance only when all of the following conditions are met:

a. the provider has an established policy for billing all patients for services not covered by a third party and/or for billing all patients for unpaid co-payment or co-insurance (non-Covered Services cannot be billed only to Enrollees.);

b. the provider has informed the Enrollee of its policy and the services and items that are not covered under this Contract and/or Medicaid co-payment or co-insurance requirements and included this information in the Enrollee's member handbook;

c. the provider has advised the Enrollee prior to rendering the service that the service is not covered under this Contract and/or that a Medicaid co-payment or co-insurance is required and that the Enrollee will be personally responsible for making payment; and

d. in the case of non-Covered Services, the Enrollee agrees to be personally responsible for the payment of the non-Covered Service and an agreement is made in writing between the provider and the Enrollee which details the service and the amount to be paid by the Enrollee.

3. CONTRACTOR May Not Hold Enrollee's Medicaid Card

The CONTRACTOR or its providers will not hold the Enrollee's Medicaid card as guarantee of payment by the Enrollee, nor may any other restrictions be placed upon the Enrollee.

4. Criminal Penalties

Criminal penalties will be imposed on Health Plan 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.

H. Survey Requirements

Surveys will be conducted of the CONTRACTOR's Enrollees that will include questions about Enrollees' perceptions of access to and the quality of care received through the CONTRACTOR. The survey process, including the survey instrument, will be standardized and developed collaboratively among the DEPARTMENT and all contracting Health Plans. The DEPARTMENT will analyze the results of the surveys. The CONTRACTOR's quality assurance committee will review the results of the surveys, identify areas needing improvement, outline action steps to follow up on findings, and inform (at a minimum), subcontractors, and member and provider services staff, when applicable.

9. General Population Survey

At least every two years, the CONTRACTOR in conjunction with the DEPARTMENT will survey a sample of its general population Enrollees; i.e., Enrollees who do not meet the definition of those with special health care needs.

2. Special Needs Survey

At least every two years, the CONTRACTOR, in conjunction with the DEPARTMENT, will survey a sample of Enrollees with special health care needs.

Article X - Measurement and Improvement Standards

A. Practice Guidelines

The CONTRACTOR and its subcontractors will adopt practice guidelines that meet the following requirements:

5. are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

6. consider the needs of the CONTRACTOR's Health Plan's Enrollees;

7. are adopted in consultation with contracting health care professionals; and

8. are reviewed and updated periodically as appropriate.

The CONTRACTOR will disseminate the practice guidelines to all affected providers and, upon request, to Enrollees and Potential enrollees.

The CONTRACTOR will 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.

B. Quality Assessment and Performance Improvement Program

1. In General

a. The Quality Assessment and Performance Improvement Program will 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 will establish an ongoing quality assessment and performance improvement program for the services it furnished to its Enrollees. CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects that would be required for the CONTRACTOR to implement. Prior to the effective date of the Contract, all plans will be reviewed by the DEPARTMENT.

2. Basic Elements of Quality Assessment and Performance Improvement Programs

At a minimum, the CONTRACTOR will comply with the following requirements:

a. Conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction.

b. Submit performance measurement data.

c. Have in effect mechanisms to detect both underutilization and overutilization of services.

d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

e. Have in effect a process for evaluating the impact and effectiveness of the quality assessment and performance improvement program.

3. Performance Measurement

Annually, the CONTRACTOR will:

a. Measure and report to the DEPARTMENT its performance, using standard measures required by the DEPARTMENT and/or CMS;

b. Submit to the DEPARTMENT, data specified by the DEPARTMENT, that enables the DEPARTMENT to measure the CONTRACTOR's performance; or

c. Perform a combination of the above activities.

4. Required areas and reporting of Performance Improvement Projects

a. The CONTRACTOR will have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:

(1) Measurement of performance using objective quality indicators.

(2) Implementation of system interventions to achieve improvement in quality.

(3) Evaluation of the effectiveness of the interventions.

(4) Planning and initiation of activities for increasing or sustaining improvement.

b. The CONTRACTOR will report the status and results of each project, including those required by CMS, to the DEPARTMENT as requested. Each performance improvement project will be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

Article XI - Other Requirements

A. Compliance with Public Health Service Act

The CONTRACTOR will comply with all requirements of Section 1301 to and including 1318 of the Public Health Service Act, as applicable. The CONTRACTOR will provide

verification of such compliance to the DEPARTMENT upon the DEPARTMENT's request.

B. Advance Directives

The CONTRACTOR will comply with the requirements of 42 CFR 434.28 relating to maintaining written Advance Directives as outlined under Subpart I of 489.100 through 489.102.

C. Fraud and Abuse Requirements

1. In General

The CONTRACTOR will have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The CONTRACTOR will have a compliance program to identify and refer suspected fraud and abuse activities.

2. Components of arrangements or procedures

The arrangements or procedures will include the following:

a. Written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable Federal and State Standards;

b. The designation of a compliance officer and a compliance committee that are accountable to senior management;

c. Effective training and education for the compliance officer and the CONTRACTOR's employees;

d. Effective lines of communication between the compliance officer and the CONTRACTOR's employees;

e. Enforcement of standards through well-publicized disciplinary guidelines;

f. Provision for internal monitoring and auditing; and

g. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract.

3. Reporting requirements related to fraud and abuse

The CONTRACTOR will:

a. Refer in writing to the DEPARTMENT all detected incidents of potential fraud or abuse on the part of providers of services to Enrollees or to other patients.

b. Refer in writing to the DEPARTMENT all detected incidents of patient fraud or abuse involving Covered Services provided which are paid for in whole, or in part, by the DEPARTMENT.

c. Refer in writing to the DEPARTMENT the names and Medicaid ID numbers of those Enrollees that the CONTRACTOR suspects of inappropriate utilization of services, and the nature of the suspected inappropriate utilization.

d. Inform the DEPARTMENT in writing when a provider is removed from the CONTRACTOR's panel for reasons relating to suspected fraud, abuse or quality of care concerns.

D. Disclosure of Ownership and Control Information

The CONTRACTOR agrees to meet the requirements of 42 CFR 455, Subpart B related to disclosure by the CONTRACTOR of ownership and control information and information related to business transactions.

E. Safeguarding Confidential Information on Enrollees

The CONTRACTOR and the CONTRACTOR's subcontractors will follow all federal and state laws, regulations, and policies governing confidential information including the applicable requirements set forth in 42 CFR part 431, subpart F; and 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act).

F. Disclosure of Provider Incentive Plans

1. The CONTRACTOR will submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(1) and summarized in this Article VII, Section F, Subsections 1 through 7, by May 1 of each year. The CONTRACTOR will provide to the DEPARTMENT the enrollee/disenrollee survey results when beneficiary surveys are required as specified in 42 CFR 417.479(g) by October 1 or three months after the end of the Contract year. The CONTRACTOR will submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(1)(vi).

2. Per 42 CFR 417.479(a), no specific payment may be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

3. The CONTRACTOR may operate a physician incentive plan only if the stop-loss protection, Enrollee survey, and disclosure requirements are met. The CONTRACTOR will disclose to the DEPARTMENT the following information on provider incentive plans in sufficient detail to determine whether the incentive plan complies with the regulatory requirements. The disclosure will contain:

   a. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of

other aspects of the plan need not be made.

   b. The type of incentive arrangement (i.e., withhold, bonus, capitation).

   c. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

   d. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

   e. The panel size and, if patients are pooled; the method used.

   f. To the extent provided for in the Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS') implementation guidelines, capitation payments paid to primary care physicians for the most recent year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider services (i.e., nursing home and home health agency) for capitated physicians or physician groups.

   g. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results. (The CONTRACTOR will conduct a customer satisfaction of both Enrollees and disenrollees if any physicians or physicians groups contracting with the CONTRACTOR are placed at substantial financial risk for referral services. The survey will include either all current Enrollees and those who have disenrolled in the past twelve months, or a sample of these same Enrollees and disenrollees. Recognizing that different questions are asked of the disenrollees than those asked of Enrollees, the same survey cannot be used for both populations.)

4. The CONTRACTOR will disclose this information to the DEPARTMENT (1) prior to approval of its Contract or agreement and (2) upon the Contract or agreements anniversary or renewal effective date. The CONTRACTOR will provide the capitation data required (see 6 above) for the previous Contract year to the DEPARTMENT three months after the end of the Contract year. The CONTRACTOR will provide to the Enrollee upon request whether the CONTRACTOR uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

Article XII - Payments

A. Non-Risk Contract

This Contract is a non-risk contract as described in 42 CFR 447.362. Aggregate payments made to the CONTRACTOR may not exceed what the DEPARTMENT would have paid, on a fee-for-service basis, in aggregate, for the services actually furnished to recipients.

B. Payment Methodology

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

C. Contract Maximum

In no event will 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 will 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.

D. Medicare

1. Payment of Medicare Part B Premiums

The DEPARTMENT will pay the Medicare Part B premium for each Enrollee who is on Medicare. The Enrollee will assign to the CONTRACTOR his or her Medicare reimbursement for benefits received under Medicare. The Eligibility Transmission includes and identifies those Enrollees who are covered under Medicare.

2. Payment of Medicare Deductible and Coinsurance

The CONTRACTOR is responsible for payment of either the Medicare coinsurance and deductible billed by Medicare or the Medicare deductible and coinsurance up to the CONTRACTOR's allowed amount for Enrollees, whichever is lower. When a service is paid for by Medicare, the CONTRACTOR will pay whether or not the service is covered under this Contract. 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. Attachment E, Table 2, will be used to identify the total cost to the CONTRACTOR of providing care for Enrollees who are also covered by Medicare.

a. The DEPARTMENT's financial obligation

The DEPARTMENT's financial obligation under this Contract for Enrollees who are covered by both Medicare and the Health Plan is limited to the Medicare Part B premium and the CONTRACTOR premium.

b. **When CONTRACTOR will pay up to the Medicaid payment rate**

For specified services, the CONTRACTOR is responsible to pay the lower

of the allowed CONTRACTOR payment rate less the amounts paid by Medicare and other payers, or the Medicare coinsurance and deductibles. The specified services are billings from:

(1) inpatient hospitals;

(2) outpatient hospitals;

(3) medical supplies defined as billings from medical suppliers and pharmacies that bill medical supplies; and

(4) physicians defined as all physician specialists except anesthesiologists, osteopaths, podiatrists, independent laboratories and independent radiology providers; and

(5) certified nurse midwives and nurse practitioners.

c. **When CONTRACTOR will pay the Medicare coinsurance and deductibles**

For crossover claims other than those listed in 2.b above, the CONTRACTOR may choose when to pay either 1) the lower of the allowed Medicaid payment rate less the amounts paid by Medicare or other payors or the Medicare coinsurance and deductibles, or 2) the coinsurance and deductibles billed by Medicare even if Medicaid's allowed amount is less than what Medicare paid.

In the event Medicaid does not have a price for a procedure code on a Medicare crossover claim, the CONTRACTOR will pay the amount of coinsurance and deductible billed by Medicare.

3. Will Not Balance Bill Enrollees

The CONTRACTOR or its providers will not Balance Bill the Enrollee and will consider reimbursement from Medicare and from the CONTRACTOR as payment in full.

E. Third Party Liability (Coordination of Benefits)

The DEPARTMENT will provide the CONTRACTOR a monthly listing of Enrollees covered under the Buy-out Program, including the premium amount paid by the DEPARTMENT.

1. TPL Collections

The CONTRACTOR will be responsible to coordinate benefits and collect third party liability (TPL). The CONTRACTOR will keep TPL collections. The DEPARTMENT's audit staff will monitor collections to ensure the

CONTRACTOR is making a good faith effort to pursue TPL.

2. Duplication of Benefits

This provision applies when, under another health insurance plan such as a prepaid plan, insurance contract, mutual benefit association or employer's self-funded group health and welfare program, etc., an Enrollee is entitled to any benefits that would totally or partially duplicate the benefits that the CONTRACTOR is obligated to provide under this Contract. Duplication exists when (1) the CONTRACTOR has a duty to provide, arrange for or pay for the cost of Covered Services, and (2) another health insurance plan, pursuant to its own terms, has a duty to provide, arrange for or pay for the same type of Covered Services regardless of whether the duty of the CONTRACTOR is to provide the Covered Services and the duty of the other health insurance plan is only to pay for the Covered Services. Under State and Federal laws and regulations, Medicaid funds are the last dollar source and all other health insurance plans as referred to above are primarily responsible for the costs of providing Covered Services.

3. Reconciliation of Other TPL

In order to assist the CONTRACTOR in billing and collecting from other health insurance plans the DEPARTMENT will include on the Eligibility Transmission other health insurance plans of each Enrollee when it is known. The CONTRACTOR will review the Eligibility Transmission and will report to the Office of Recovery Services or the DEPARTMENT any TPL discrepancies identified within 30 working days of receipt of the Eligibility Transmission. The CONTRACTOR's report will include a listing of

Enrollees that the CONTRACTOR has independently identified as being covered by another health insurance plan.

4. When TPL is Denied

On a monthly basis, the CONTRACTOR will report to the Office of Recovery Services (ORS) claims that have been billed to other health care plans but have been denied which will include the following information:

a. patient name and Medicaid identification number;

b. ICD-9-CM code;

c. procedure codes; and

d. insurance company.

5. Notification of Personal Injury Cases

The CONTRACTOR will be responsible to notify ORS of all personal injury cases, as defined by ORS and agreed to by the CONTRACTOR, 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.

The following data elements will be provided by the CONTRACTOR to ORS:

a. patient name and Medicaid identification number;

b. CONTRACTOR's patient number;

c. dates of service;

d. provider billed amount;

e. TPL collected amount;

f. TPL name;

g. amount paid by CONTRACTOR;

h. amount paid by Medicaid;

i. servicing provider name;

j. specific type of injury by ICD-9-CM code; and

k. procedure codes.

6. ORS to Pursue Collections

ORS will pursue collection on all claims described in this Article XII (Payments), Section E, Subsections 4 and 5 of this Contract. The DEPARTMENT will retain, for administrative costs, one third of the collections received for the period during which medical services were provided by the CONTRACTOR, and remit the balance to the CONTRACTOR.

7. Insurance Buy-Out Program

The Insurance Buy-out Program is an optional program in which the DEPARTMENT purchases group health insurance for a recipient who is eligible for Medicaid when it is determined cost-effective for the Medicaid program to do so. The insurance buy-out process will be coordinated by the DEPARTMENT in cooperation with the Office of Recovery Services, and Medicaid eligibility workers. The CONTRACTOR will file claims against group Health Plan's first before claiming services against the CONTRACTOR or other Health Plans.

8. CONTRACTOR Will Pay Provider Administrative Fee for Immunizations

When an Enrollee has third party coverage for immunizations, the CONTRACTOR will pay the provider the administrative fee for providing the immunization and not require the provider to bill the third party as a cost avoidance method. The CONTRACTOR may choose to pursue the third party amount for the administrative fee after payment has been made to the provider.

F. Third Party Responsibility (Including Worker's Compensation)

1. CONTRACTOR to Bill Usual and Customary Charges

When a third party has an obligation to pay for Covered Services provided by the CONTRACTOR to an Enrollee pursuant to this Contract, the CONTRACTOR will bill the third party for the usual and customary charges for Covered Services provided and costs incurred. Should any sum be recovered by the Enrollee or otherwise, from or on behalf of the person responsible for payment for the service, the CONTRACTOR will be paid out of such recovery for the charges for service provided and costs incurred by the CONTRACTOR.

2. Third Party's Obligation to Pay for Covered Services

Examples of situations where a third party has an obligation to pay for Covered Services provided by the CONTRACTOR are when (a) the Enrollee is injured by a person due to the negligent or intentional acts (or omissions) of the person; or (b) the Enrollee is eligible to receive payment through Worker's Compensation Insurance. If the Enrollee does not diligently seek such recovery, the CONTRACTOR may institute such rights that it may have.

3. First Dollar Coverage for Accidents

In addition, both parties agree that the following will apply regarding first dollar coverage for accidents: if the injured party has additional insurance, primary coverage may be given to the motor insurance effective at the time of the accident. Once the motor vehicle policy is exhausted, the CONTRACTOR will be the secondary payer and pay for all of the Enrollee's Covered Services. If medical insurance does not exist, the CONTRACTOR will be the primary payer for all Covered Services.

G. Changes in Covered Services

If Covered Services are amended under the provisions of Attachment B, Article IV (Benefits), rates may be renegotiated, if applicable.

H. Clarification of Payment Responsibilities

1. Covered Services Received Outside CONTRACTOR's Network but Paid by CONTRACTOR

The CONTRACTOR will not be required to pay for Covered Services, defined in Attachment C, which the Enrollee receives from sources outside the CONTRACTOR's network, not arranged for and not authorized by, the CONTRACTOR except as follows:

a. Emergency Services;

b. Court ordered services that are Covered Services defined in Attachment C and which have been coordinated with the CONTRACTOR; or

c. Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable from the CONTRACTOR.

2. Payment to Non-Network Providers and to Providers out of the Service Area

Payment by the CONTRACTOR to an out-of-network provider for emergency services and/or to a provider out of the Service Area for services that are approved for payment by the CONTRACTOR will 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:

a. The usual charges made to the general public by the provider;

b. The rate equal to the applicable Medicaid fee-for-service rate; or

c. The rate agreed to by the CONTRACTOR and the provider.

3. When Covered Services 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 will 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 will be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.

4. The DEPARTMENT's Responsibility

Except as described in Attachment F (Payment Methodologies) of this Contract, the DEPARTMENT will not be required to pay for any Covered Services under Attachment C which the Enrollee received from any sources outside the CONTRACTOR except for family planning services.

5. Covered Services Provided by the Department of Health, Division of Community and Family Health Services

a. For Enrollees who qualify for special services offered by or through the Department of Health, Division of Community and Family Health Services (DCFHS), the CONTRACTOR agrees to reimburse DCFHS 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 both becomes Medicaid eligible and selects the CONTRACTOR as its provider.

(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 will reimburse DCFHS 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 DCFHS for children with special health care needs, the CONTRACTOR may subcontract with DCFHS. The CONTRACTOR agrees that the subcontract with DCFHS will acknowledge and address the specific needs of DCFHS as a government provider.

6. Enrollee Transition Between Health Plans, or Between Fee-For-Service and CONTRACTOR

a. Inpatient Hospital

(1) When an Enrollee is in an inpatient hospital setting and selects another Health Plan or becomes fee-for-service anytime prior to

discharge from the hospital, the CONTRACTOR is financially responsible for the entire hospital stay including all services related to the hospital stay (i.e. physician, etc.), unless responsibility is transferred to another appropriate entity and the entity agrees to take financial responsibility, including negotiating a payment for services (see Article IV, Benefits, Section C.4., Inpatient Hospital Services for Scheduled Admissions).

(2) The Health Plan in which the individual is enrolled when discharged from the hospital is financially responsible for services provided during the remainder of the month when the individual was discharged.

(a) If such 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.

(b) If a Medicaid eligible is fee-for-service when admitted to the hospital and selects a Health Plan anytime prior to discharge from the hospital, the DEPARTMENT is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc.

(3) When an Enrollee is in an inpatient hospital setting at the time the CONTRACTOR terminates this Contract and the Enrollee selects another Health Plan anytime prior to discharge from the hospital, the receiving Health Plan is financially responsible for the hospital stay beginning 30 days after termination of the Contract.

b. Home Health Services

(1) Medicaid clients who are under fee-for-service or are enrolled in a Health Plan other than this Health Plan and are receiving home health services from an agency not contracting with the CONTRACTOR will be transitioned to the CONTRACTOR's home health agency.

(2) The CONTRACTOR is responsible for payment, not to exceed Medicaid payment, for a period not to exceed seven calendar days, unless the CONTRACTOR notifies the non-participating home health agency of the change in status or the non-participating home health agency notifies the CONTRACTOR that services are bing provided by its agency.

(3) The CONTRACTOR will assess the needs of the Enrollee at the time the CONTRACTOR provides the orientation to the Enrollee.

(4) The CONTRACTOR will 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 will address

Enrollee's concerns regarding Covered Services provided by the CONTRACTOR's home health agency before the new plan of care is implemented.

c. ***Medical Equipment***

(1) 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 payment of such equipment.

(2) When medical equipment is ordered for a Medicaid eligible by the DEPARTMENT and the Enrollee selects a Health Plan, the DEPARTMENT is responsible for payment of such equipment.

(3) 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 is the responsibility of the Health Plan in which the client is enrolled at the time such equipment is ordered.

7. Surveys

e. All surveys required under this Contract will be funded by the CONTRACTOR unless funded by another source such as the Utah Department of Health, Office of Health Care Statistics.

f. The surveys will be conducted by an independent vendor mutually agreed upon by the DEPARTMENT and CONTRACTOR.

g. The DEPARTMENT or designee will analyze the results of the surveys. Before publishing articles, data, reports, etc. related to surveys, the DEPARTMENT will provide drafts of such material to the CONTRACTOR for review and feedback.

h. The CONTRACTOR will not be responsible for the costs incurred for such publishing by the DEPARTMENT.

Article XIII - Records and Reporting Requirements

A. Health Information Systems

The CONTRACTOR will retain records in accordance with requirements of 45 CFR 74 (three years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original three year period ends).

1. General Rule

The CONTRACTOR will maintain a health information system that collects, analyzes, integrates, and reports data. The system will provide information on areas including, but not limited to, utilization, Grievances and Appeals, and disenrollments for other than loss of Medicaid eligibility.

2. Basic Elements of a Health Information System

In accordance with Section 4752 of OBRA '90 (amended section 1903 (m)(2)(A) of the Social Security Act), the CONTRACTOR agrees to maintain sufficient patient encounter data to identify the physician who delivers Covered Services to Enrollees.

a. The CONTRACTOR agrees to provide this encounter data, upon request of the DEPARTMENT, within 30 days of the request.

b. At a minimum, the CONTRACTOR will collect data on Enrollee and provider characteristics as specified by the DEPARTMENT and on services furnished to Enrollees through an encounter data system.

3. Accuracy of Data

a. The CONTRACTOR will ensure that data received from providers is accurate and complete by:

(1) verifying the accuracy of 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 will make all collected data available to the DEPARTMENT and upon request to CMS.

4. Medical Records

The CONTRACTOR agrees that medical records are considered confidential information and agrees to follow Federal and State confidentiality requirements.

a. The CONTRACTOR will require that its providers maintain a medical record keeping system through which all pertinent information relating to the medical management of the Enrollee is maintained, organized, and is readily available to appropriate professionals.

b. Notwithstanding any other provision of this Contract to the contrary, medical records covering Enrollees will remain the property of the provider, and the provider will respect every Enrollee's privacy by restricting the use and disclosure of information in such records to purposes directly connected with the Enrollee's health care and administration of this Contract.

c. The CONTRACTOR will use and disclose information pertaining to individual Enrollees and prospective Enrollees only for purposes directly connected with the administration of the Medicaid Program and this Contract.

B. Federally Required Reports

1. CHEC/EPSDT Reports

The CONTRACTOR agrees to act as a continuing care provider for the CHEC/EPSDT program in compliance with OBRA '89 and Social Security Act Sections 1902 (a)(43), 1905 (a)(4)(B) and 1905 (r).

a. CHEC/EPSDT Screenings

(1) Annually, the CONTRACTOR will submit to the DEPARTMENT information on CHEC/EPSDT screenings to meet the Federal EPSDT reporting requirements (Form CMS-416). The data will be in a mutually agreed upon format.

(2) The CHEC/EPSDT information is due December 31 for the prior federal fiscal year's data (October 1 through September 30).

b. Immunization Data

The CONTRACTOR will submit immunization data as part of the CHEC/EPSDT reporting. Enrollee name, Medicaid ID, type of immunization identified by procedure code, and date of immunization will be reported in the same format as the CHEC/EPSDT data.

1. Disclosure of Physician Incentive Plans

a. The CONTRACTOR will submit to the DEPARTMENT information on its physician incentive plans as listed in 42 CFR 417.479(h)(1) by May 1 of each year.

b. The CONTRACTOR will provide to the DEPARTMENT the enrollee/disenrollee survey results when beneficiary surveys are required as specified in 42 CFR 417.479(g) by October 1 or three months after the end of the Contract year.

c. The CONTRACTOR will submit to the DEPARTMENT information on capitation payments paid to primary care physicians as specified in 42 CFR 417.479(h)(1)(vi).

C. Periodic Reports

1. Enrollment, Cost and Utilization Reports (Attachment E)

a. Enrollment, cost and utilization reports will be submitted on diskettes or CDs in Excel and in the format specified in Attachment E. A hard copy of the report will be submitted as well. The DEPARTMENT will send to the CONTRACTOR a template of the Attachment E format on a diskette, CD, or electronically.

b. The CONTRACTOR may not customize or change the report format. The financial information for these reports will be reported as defined in CMS Publication 75, and if applicable, CMS 15-1.

c. The CONTRACTOR will certify in writing the accuracy and completeness, to the best of its knowledge, of all costs and utilization data provided to the DEPARTMENT on Attachment E.

d. Two Attachment E reports will be submitted covering dates of service for each Contract year.

(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).

e. If necessary, the CONTRACTOR may request, in writing, an extension of the due date up to 30 days beyond the required due date. The DEPARTMENT will approve or deny the extension request writing within seven calendar days of receiving the request.

2. Interpretive Services

Annually, on November 1, the CONTRACTOR will submit summary information about the use of interpretive services during the previous Contract year (July 1

through June 30). The information will include the following:

a. a list of all sources of interpreter services;

b. total expenditures for each language;

c. total expenditures for clinical versus administrative;

d. number of Enrollees who used interpretive services for each language; and

e. number of services provided categorized by clinical versus administrative.

3. Semi-Annual Reports

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).

a. Organ Transplants: Report the total number of organ transplants by type of transplant.

b. Obstetrical Information: Report obstetrical information including:

(1) total number of obstetrical deliveries by aid category grouping;

(2) total number of caesarean sections and total number of vaginal deliveries;

(3) total number low birth weight infants; and

(4) total number of Enrollees requiring prenatal hospital admission.

c. Appeals and Grievances

The CONTRACTOR will maintain complete records of all Appeals and Grievances and submit semi-annual reports summarizing Appeals and Grievances using DEPARTMENT-specified reporting templates.

(1) Separate reports of Appeals and Grievances are required for adults and children; and for Traditional Medicaid Plan Enrollees and Non-Traditional Plan Enrollees.

(2) Each report will distinguish between those Enrollees with special health care needs and the general population of children.

(3) Report summary information on the number of Appeals and Grievances by type of Appeals and Grievance and indicate the number that have been resolved. Include an analysis of the type and number of Appeals and Grievances received by the CONTRACTOR.

d. Aberrant Physician Behavior

Report summary information of corrective actions taken on physicians who have been identified by the CONTRACTOR as exhibiting aberrant physician behavior and the names of physicians who have been removed from the CONTRACTOR's network due to aberrant behavior. The summary will include the reasons for the corrective action or removal.

4. Annual Quality Improvement Program Documentation

a. Annually, the CONTRACTOR will submit to the DEPARTMENT the following documents:

(1) the CONTRACTOR's quality improvement program description;

(2) the CONTRACTOR's quality improvement work plan;

(3) the CONTRACTOR's quality improvement work plan evaluation for previous calendar year.

b. These reports will be in the format developed by the DEPARTMENT and include signature(s) of approval by the CONTRACTOR's designated authorizing authority. Reports will be on a Contract year basis and will be due no later that October 1st of each year.

5. Documents Due Prior to Quality Monitoring Reviews

a. The following documents are due at least 60 days prior to the DEPARTMENT's quality assurance monitoring review, or earlier on request, unless the DEPARTMENT has already received documents that are in effect:

(1) the CONTRACTOR's most current (may be in draft stage) written quality improvement program description;

(2) the CONTRACTOR's most current (may be in draft stage) annual quality improvement work plan;

(3) the CONTRACTOR's most current (may be in draft stage) quality improvement work plan evaluation for the previous calendar year;

(4) documentation of the CONTRACTOR's compliance to standards

defined in Utah's Quality Assessment and Performance Improvement Plan for contracted medical health plans (Attachment D).

(5) all other information requested by the DEPARTMENT to facilitate the DEPARTMENT's review of the CONTRACTOR's compliance to standards defined in Utah's Quality Assessment and Performance Improvement Plan for contracted medical health plans (Attachment D).

b. The above documents will show evidence of a well defined, organized program designed to improve client care.

6. Impact of Co-payments

a. The following semi-annual report is due ***May 1*** for the preceding six-month reporting period ending April 30 (November of previous year through April of current year) and ***November 1*** for the preceding six-month period ending October 31 (May through October of the current year):

b. Report will document all instances when Enrollees have contacted the CONTRACTOR with a complaint about being denied services because they did not pay their Medicaid co-payment or co-insurance. For each instance, report the Enrollee's name, Medicaid ID, provider, and the service the Enrollee was scheduled to receive.

7. HEDIS

Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered to Enrollees and will be reported as set forth in State rules by the Office of Health Data Analysis. For example, calendar year 2003 HEDIS measures will be reported in 2004.

8. Encounter Data

a. Encounter data will be submitted in accordance with the instructions detailed in the Encounter Records 837 Institutional Guide and Encounter Records 837, Professional Companion Guide, for dates of service beginning July 1, 2002.

b. The CONTRACTOR will receive certification from an independent, credible vendor that their electronic submissions of encounter data are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

c. At a minimum, the CONTRACTOR will be HIPAA-compliant in the first four levels of HIPAA compliance: Level 1 - Integrity Testing, Level 2 - Requirement Testing, Level 3 - Balancing, and Level 4 - Situation Testing.

9. Audit of Abortions, Sterilizations and Hysterectomies

a. The CONTRACTOR will 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. The CONTRACTOR will 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 will 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, submit documentation of the methodology used to pull the sample of sterilization and hysterectomies and include the sampling proportions.

d. In an Excel file, 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) medical necessity criteria - hysterectomies only

e. When information is submitted electronically, the CONTRACTOR will use a secured electronic transmission process.

f. The DEPARTMENT will evaluate the results of the CONTRACTOR's audit and identify the cases that will require medical record submission.

(1) Medical record submission will be required for all abortions and a random sample of hysterectomy and sterilization cases.

(2) The DEPARTMENT will notify the CONTRACTOR in writing of the cases that will require medical record submission and the time line for the medical record submissions.

10. Provider Network

The CONTRACTOR will submit a monthly file of its provider network that meets the DEPARTMENT's provider file specifications and data element requirements.

11. Case Management Reports

The CONTRACTOR will submit quarterly case management reports due 30 days after the end of each quarter being reported; i.e., data covering July through September is due November 1. (See Utah's Quality Assessment and Performance

Improvement Plan, Attachment D).

12. Development of New Reports

Any new reports/data requirements mandated by the DEPARTMENT will be mutually developed by the DEPARTMENT and the CONTRACTOR.

D. Data Certification

1. Certifications

The CONTRACTOR will certify financial data that are submitted to the DEPARTMENT.

2. Timing of Certification for Financial Data and Reports

a. When submitting paper copies of the financial data or reports, the CONTRACTOR may submit the written certification by using the DEPARTMENT-developed data and reports cover sheet which includes a certification statement.

b. If the CONTRACTOR does not use the cover sheet, the CONTRACTOR will attach a cover letter that includes the data certification statement.

c. When submitting data and reports electronically, the CONTRACTOR will include a certification statement with the submission.

3. Content of Certification

In the certification, the CONTRACTOR will attest to the completeness and truthfulness of the data and documents based on best knowledge, information and belief.

4. Authority to Certify

The CONTRACTOR will ensure one of the following certifies data and documents:

a. the CONTRACTOR's chief executive officer;

b. the CONTRACTOR's chief financial officer; or

c. an individual who has delegated authority to sign for, and who reports directly to the chief executive officer or chief financial officer.

Article XIV - Compliance/Monitoring

A. Audits

1. Right of DEPARTMENT and CMS to Audit

The DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services may audit and inspect any financial records of the CONTRACTOR or its subcontractors relating (a) to the ability of the CONTRACTOR to bear the risk of potential financial losses, or (b) to evaluate services performed or determinations of amounts payable under the Contract.

2. Information to Determine Allowable Costs

The CONTRACTOR will make available to the DEPARTMENT 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 in CMS 15-1. These records are to be made available in Utah or the CONTRACTOR will pay the increased cost (incremental travel, per diem, etc.) of auditing at the out-of-state location. The cost to the CONTRACTOR will include round-trip travel and two days per diem/lodging. Additional travel costs of the site audit will be shared equally by the CONTRACTOR and the DEPARTMENT.

3. Management and Utilization Audits

(1) The CONTRACTOR will allow the DEPARTMENT and the Department of Health and Human Services, Centers for Medicare and Medicaid Services, 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 and utilization data, which will include patient profiles, exception reports, etc.

(2) The CONTRACTOR will provide all data required by the DEPARTMENT or the independent quality review examiners in performance of these audits.

(3) Prior to beginning any audit, the DEPARTMENT will give the CONTRACTOR reasonable notice of audit, and the DEPARTMENT will be responsible for costs of its auditors or representatives.

B. Quality Monitoring by the DEPARTMENT

1. The DEPARTMENT will review, at least annually, the impact and effectiveness of the CONTRACTOR's quality assessment and performance improvement program. The review will include:

a. The CONTRACTOR's performance on the standard measures on which it is required by the DEPARTMENT to report.

b. The results of the CONTRACTOR's performance improvement projects.

c. The results of the CONTRACTOR's evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

1. The DEPARTMENT will review the CONTRACTOR for compliance to standards defined in Utah's Quality Assessment and Performance Improvement Plan (Attachment D).

C. External Quality Review

1. In General

a. Pursuant to 42 CFR Part 438 Subpart E - External Quality Review (EQR), the DEPARTMENT will provide for an annual external quality review conducted by an External Quality Review Organization (EQRO) of the quality, timeliness, and access to Covered Services. The CONTRACTOR will support the annual external quality review.

b. The DEPARTMENT will choose an agency to perform an annual EQR pursuant to Federal law and will pay for such review.

(1) The CONTRACTOR will maintain all clinical and administrative records for use by the EQRO.

(2) The CONTRACTOR agrees to support quality assurance reviews, focused studies and other projects performed for the DEPARTMENT by the EQRO.

(3) The purpose of the reviews and studies is to comply with Federal requirements for an annual EQR.

(4) The external quality reviews are conducted by the EQRO, with the advice, assistance, and cooperation of a planning team composed of representatives from the CONTRACTOR, the EQRO and the DEPARTMENT with final approval by the DEPARTMENT.

2. Specific Requirements

a. Liaison for Routine Communication

The CONTRACTOR will designate an individual to serve as liaison with the EQRO for routine communication with the EQRO.

b. Representative to Assist with Projects

(1) The CONTRACTOR will designate a minimum of two representatives (unless one individual can service both functions) to serve on the planning team for each EQRO project.

(2) Representatives will include a quality improvement representative and a data representative.

(3) The planning team is a joint collaborative forum between DEPARTMENT staff, the EQRO and the CONTRACTOR.

(4) The role of the planning team is to participate in the process and completion of EQRO projects.

c. Copies and On-Site Access

(1) The CONTRACTOR will be responsible for obtaining copies of Enrollee information and facilitating on-site access to Enrollee information as needed by the EQRO. Such information will be used to plan and conduct projects and to investigate complaints and grievances.

(2) Any associated copying costs are the responsibility of the CONTRACTOR.

(3) Enrollee information includes medical records, administrative data such as, but not limited to, enrollment information and claims, nurses' notes, medical logs, etc. of the CONTRACTOR or its providers.

d. Format of Enrollee Files

The CONTRACTOR will provide Enrollee information in a mutually agreed upon format compatible for the EQRO's use, and in a timely fashion to allow the EQRO to select cases for its review.

e. Time-frame for Providing Data

(1) The CONTRACTOR will provide data to the EQRO within 15 working days of the written request from the EQRO and will provide medical records within 30 working days of the written request from the EQRO.

(2) Requests for extensions of these time frames will be reviewed and approved or disapproved by the DEPARTMENT on a case-by-case basis.

f. Work Space for On-Site Reviews

The CONTRACTOR will assure that the EQRO staff and consultants have

adequate work space, access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.

g. Staff Assistance During On-Site Visits

The CONTRACTOR will assign appropriate person(s) to assist the EQRO personnel conduct the reviews during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.

D. Corrective Action

1. When Corrective Actions are Necessary

a. The CONTRACTOR agrees to implement corrective action as specified by the DEPARTMENT when quality assurance monitoring including, but not limited to, site reviews, CONTRACTOR documentation reviews, data analysis, medical audits, or complaints/grievances, determines the need for such corrective action.

b. In addition, if the DEPARTMENT determines that the CONTRACTOR has not provided services in accordance with the Contract or within expected professional standards, the DEPARTMENT will request in writing that the CONTRACTOR correct deficiencies or identified problems by developing a corrective action plan.

c. If the corrective action is a result of non-compliance with the DEPARTMENT's Quality Assessment Improvement and Performance Improvement Plan, the time frames below do not necessarily apply; the time frames will be specified in a formal letter sent to the CONTRACTOR from the DEPARTMENT if a corrective action is required.

2. Initial Response by CONTRACTOR

a. The CONTRACTOR has 20 working days from the date the DEPARTMENT mails, through certified mail, its written request for the CONTRACTOR to respond to the problems identified and will either:

(1) submit a corrective action plan,

(2) submit a letter summarizing the CONTRACTOR's disagreements with the DEPARTMENT's findings, or

(3) request, in writing, an extension of the 20-day time frame. The CONTRACTOR may only request an extension if it determines it will conduct a medical records review or there are other extenuating circumstances.

b. If the CONTRACTOR fails to respond in one of the above ways, the CONTRACTOR will be subject the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted to the DEPARTMENT.

3. Submission of Corrective Action to DEPARTMENT

a. Acceptance of Corrective Action Plan

If the CONTRACTOR submits a corrective action plan to the DEPARTMENT within 20 working days (or other agreed upon time frame) and the DEPARTMENT accepts the corrective action plan, the DEPARTMENT will send written notice to the CONTRACTOR officially approving the corrective action plan.

b. When Corrective Action Plan Requires Revisions

(1) If the CONTRACTOR submits a corrective action plan, but the DEPARTMENT determines the corrective action plan requires revisions, the CONTRACTOR will have 20 working days to submit a revised plan from the date the DEPARTMENT mails, through certified mail, the request for a revised plan. The DEPARTMENT's letter will state the specific revisions to be made in the corrective action plan.

(2) If the CONTRACTOR is unable or unwilling to submit to the DEPARTMENT within the established time frame, a revised corrective action plan containing the DEPARTMENT's requested revisions, the CONTRACTOR will be subject to the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted to the DEPARTMENT.

4. Initial Appeal of DEPARTMENT's Findings

a. If the CONTRACTOR disagrees with the DEPARTMENT's findings and wishes to appeal those findings, the CONTRACTOR will submit a detailed explanation of the disagreement in writing to the DEPARTMENT within the established time frame. If the DEPARTMENT agrees with the CONTRACTOR, the DEPARTMENT will provide written notification of its decision and will withdraw the request for a corrective action plan.

b. If the DEPARTMENT upholds its request for a corrective plan, the CONTRACTOR has 20 days from the date the DEPARTMENT mails, through certified mail, a letter upholding its request for a corrective action plan.

c. If the CONTRACTOR does not submit a corrective action plan within that

time frame, the CONTRACTOR will be subjected to the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan is submitted.

5. Formal Hearing

a. If the DEPARTMENT upholds its decision that a corrective action plan is required, the CONTRACTOR may file a request for a formal hearing with the DEPARTMENT within 30 days from the date the DEPARTMENT mails, through certified mail, a letter upholding its decision. If the $500 penalty has begun, it will discontinue once the DEPARTMENT receives the formal hearing request from the CONTRACTOR.

b. If the outcome of the formal hearing is in favor of the CONTRACTOR, the DEPARTMENT will provide the CONTRACTOR with written notification that a corrective action plan is no longer required. The DEPARTMENT will reimburse the CONTRACTOR any penalties the CONTRACTOR has paid to the DEPARTMENT that accrued beginning on day 21 from the date the DEPARTMENT mails, through certified mail, the request for a corrective action plan and ending on the day the request for a formal hearing is received by the DEPARTMENT.

c. If the outcome of the formal hearing is in favor of the DEPARTMENT, the CONTRACTOR will submit a corrective action plan, as determined by the formal hearing decision, within 20 days of the date of the hearing decision, otherwise the CONTRACTOR will be subject to the following sanction:

A $500 penalty for each working day, beginning on the first day after the 20-day time period has expired, and continuing until the day a corrective action plan that complies with the formal hearing decision is submitted to the DEPARTMENT. If the DEPARTMENT determines that the corrective action plan requires revisions, the CONTRACTOR will again be subject to a $500 penalty for each working day beginning on the first day after the DEPARTMENT verbally notifies the CONTRACTOR that the corrective action plan requires revisions and continuing until the day the DEPARTMENT receives the corrective action plan containing the DEPARTMENT's required revisions.

6. CONTRACTOR Unwilling or Unable to Implement Corrective Action Plan

a. If the CONTRACTOR is unwilling or unable to implement the corrective action plan to the satisfaction of the DEPARTMENT, the CONTRACTOR will be subject to the following sanction:

A $500 penalty for each working day, beginning on the first day after the DEPARTMENT verbally notifies the CONTRACTOR that the corrective action plan has not been implemented, and continuing

until the day the CONTRACTOR successfully demonstrates to the DEPARTMENT that it has implemented the plan. Following the DEPARTMENT's verbal notification, the DEPARTMENT will mail, through certified mail, a letter stating the penalty has been invoked.

b. The CONTRACTOR will be apprized of its right to request a formal hearing.

(1) If the CONTRACTOR decides to formally appeal the DEPARTMENT's decision that the corrective action plan has not been implemented, then the procedures detailed in number 2 above apply.

(2) If the outcome of the formal hearing is in favor of the DEPARTMENT, penalties will resume on the date of the formal hearing decision and continue until the CONTRACTOR complies with the decision of the formal hearing.

7. Collection of Financial Penalties

The DEPARTMENT may deduct any financial penalties assessed by the DEPARTMENT from the monthly payment to the CONTRACTOR.

Article XV - Termination of the Contract

A. Automatic Termination

This Contract will automatically terminate June 30, 2006. The parties agree to meet prior to the end date of this Contract to discuss terms and conditions that may be incorporated into the next Contract period, unless terminated by either party as provided herein.

B. 90-Day Termination Option

Either party may terminate the Contract without cause by giving the other party written notice of termination at least 90 days prior to the termination date.

C. Effect of Termination

1. Coverage

Inasmuch as the CONTRACTOR is paid on a monthly basis, the CONTRACTOR will continue providing the Covered Services required by this Contract until midnight of the last day of the calendar month in which the termination becomes effective. If an Enrollee is a patient in a hospital setting during the month in which termination becomes effective, the CONTRACTOR is responsible for the entire hospital stay including physician charges until discharge or thirty days following termination, whichever occurs first.

2. Enrollee Not Liable for Debts of CONTRACTOR or its Subcontractors

If the CONTRACTOR or one of its subcontractors becomes insolvent or bankrupt, the Enrollees will not be liable for the debts of the CONTRACTOR or its subcontractor. The CONTRACTOR will include this term in all of its subcontracts.

3. Information for Claims Payment

The CONTRACTOR will promptly supply to the DEPARTMENT all information necessary for the reimbursement of any Medicaid claims not paid by the CONTRACTOR.

4. Changes in Enrollment Process

The CONTRACTOR will be advised of anticipated changes in policies and procedures as they relate to the enrollment process and their comments will be solicited. The CONTRACTOR agrees to be bound by such changes in policies and procedures unless they are not

agreeable to the CONTRACTOR, in which case the CONTRACTOR may terminate the Contract in accordance with the Contract termination provisions.

5. Hearing Prior to Termination

Regarding the General Provisions, Article XVII (Default, Termination, & Payment Adjustment), item 3, if the CONTRACTOR fails to meet the requirements of the Contract, the DEPARTMENT will give the CONTRACTOR a hearing prior to termination. Enrollees will be informed of the hearing and will be allowed to disenroll from this Health Plan without cause.

6. CMS Consent Required

If the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) directs the DEPARTMENT to terminate this Contract, the DEPARTMENT will not be permitted to renew this Contract without CMS consent.

D. 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 any part of the rights or obligations under this Contract will be deemed an assignment. Consent may be withheld in the DEPARTMENT's sole and absolute discretion.

Article XVI - Miscellaneous

A. Integration

This Contract contains 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 will not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof. If there is a conflict between these Special Provisions (Attachment B) or the General Provisions (Attachment A), then these Special Provisions will control.

B. Enrollees May Not Enforce Contract

Although this Contract relates to the provision of benefits for Enrollees and others, no Enrollee is entitled to enforce any provision of this Contract against the CONTRACTOR nor will any

provision of this Contract be constructed to constitute a promise by the CONTRACTOR to any Enrollee or Potential Enrollee.

C. Interpretation of Laws and Regulations

The DEPARTMENT will 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 will submit written requests to the DEPARTMENT. The DEPARTMENT will retain full authority and responsibility for the administration of the Medicaid program in accordance with the requirements of Federal and State law.

D. Adoption of Rules

Adoption of rules by the DEPARTMENT which govern the Medicaid program, will be automatically incorporated into this Contract upon receipt by the CONTRACTOR of written notice thereof.

Attachment C
Molina Healthcare of Utah
January 1, 2006

Covered Services
Limitations & Exclusions
Co-payment & Co-insurance Requirements

Covered Services are the same under both the Traditional and Non-Traditional Medicaid Plans unless otherwise indicated. Co-payments and co-insurances are listed if required. **Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements.** Medicaid Provider Manuals provide detailed information regarding covered services and are available to the CONTRACTOR upon request.

A. In General

The CONTRACTOR will provide the following benefits to Enrollees in accordance with Medicaid benefits as defined in the Utah State Plan subject to the exception or limitations as noted below. The DEPARTMENT reserves the right to interpret what is in the State plan. Medicaid services can only be limited through utilization criteria based on Medical Necessity. The CONTRACTOR will provide at least the following benefits to Enrollees.

The CONTRACTOR is responsible to provide or arrange for all Medically Necessary Covered Services on an emergency basis 24 hours each day, seven days a week. The CONTRACTOR is responsible for payment for all covered Emergency Services furnished by providers that do not have arrangements with the CONTRACTOR.

B. Hospital Services

1. Inpatient Hospital

Services furnished in a licensed, certified hospital are Covered Services.

Non-Traditional Medicaid Plan excludes the following revenue codes:
430 - 439 (Occupational Therapy)
380 - 382, and 391 (Whole Blood)
390 and 399 (Autologous or self blood storage for future use)
811 - 813 (Organ Donor charges)

CO-INSURANCE
Traditional Medicaid: $220.00 for non-emergency admissions. Limited to $220.00 per Enrollee per calender year.
Non-Traditional Medicaid: $220.00 for each non-emergency admission per Enrollee. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

2. Outpatient Hospital

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

CO-PAYMENT

Traditional Medicaid: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or free-standing ambulatory surgical centers are subject to $2.00 co-payment per date of service per provider. Annual calendar year maximum for any combination of physician, podiatry, outpatient hospital, and surgical centers is $100.00 per Enrollee.

Non-Traditional Medicaid: $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. The facility fees associated with services provided in an outpatient hospital or a free standing ambulatory surgical centers are subject to $3.00 co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

3. Emergency Department Services

Emergency Services provided to Enrollees in designated hospital emergency departments are Covered Services.

CO-PAYMENT

Traditional Medicaid: Co-payment is $6.00 for non-emergency use of the emergency room.

Non-Traditional Medicaid: Co-payment is $6.00 for non-emergency use of the emergency room. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

C. Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision are covered Services.

Non-Traditional Medicaid excludes office visits in conjunction with allergy injections (CPT codes 95115 through 95134 and 95144 through 95199).

CO-PAYMENT

Traditional Medicaid: Co-pay is $3.00 per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, osteopath, podiatry, outpatient hospital, freestanding

emergency centers, and surgical centers. Co-payment required for preventive services and immunizations.

Non-Traditional Medicaid: Co-payment is $3.00 per visit. Limited to one co-payment per date of service per provider. No co-payment for preventive services and immunizations. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

D. General Preventive Services

The CONTRACTOR must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional groups such as the American Academy of Pediatric and the U.S. Task Force on Preventive Care.

A minimum of three screening programs for prevention or early intervention (e.g. Pap Smear, diabetes, hypertension).

E. Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice are Covered Services. Services include, but are not limited to, the following:

1. Eye examinations and care to identify and treat medical problems
2. Eye refractions, examinations
3. Laboratory work
4. Lenses
5. Eyeglass Frames
6. Repair of Frames
7. Repair or Replacement of Lenses
8. Contact Lenses (when Medically Necessary)

Traditional Medicaid Plan: Full coverage for all Non-Traditional clients.

Non-Traditional Medicaid Plan is limited to the following services and limitations: Non-Traditional Medicaid clients have coverage for vision screening in conjunction with determining refractions. Providers may bill using procedure codes 92002, 92004, 92012, and 92014. There is a maximum Medicaid benefit of $31.21 for screening services. Charges above the $31.21 are non-covered Medicaid services and are considered the patient's responsibility. Eye refraction/examination is limited to one eye examination every 12 months.

Eyeglasses (lenses and frames) are not covered.

Services to identify and treat medical problems such as diabetic retinopathy, glaucoma, cataracts, etc., may be billed by ophthalmologists and optometrists using procedure codes

92020, 92083, 92135, 95930, 99201-99205, 99211-99215, 65210, 65220, 65222, 67820, 68761, and 68801. Ophthalmologists may bill additional procedure codes within their scope of service that are covered by Medicaid. These services are paid based on the Medicaid fee schedule and are considered payment in full.

F. Lab and Radiology Services

Professional and technical laboratory and X-ray services furnished by licensed and certified providers are Covered Services. All laboratory testing sites, including physician office labs, providing services under this Contract will have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

G. Physical and Occupational Therapy

1. Physical Therapy

Treatment and services provided by a licensed physical therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified physical therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

2. Occupational Therapy

Treatment of services provided by a licensed occupational therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to an Enrollee by or under the direction of a qualified occupational therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

Non-Traditional Medicaid: Physical therapy and occupational therapy (in combination) are limited to 10 visits per calendar year.

CO-PAYMENT

Non-Traditional Medicaid: $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

H. Speech and Hearing Services

Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss are Covered Services.

Non-Traditional Medicaid Plan: Full coverage except hearing aids are limited to congenital (birth defect) hearing losses only.

I. Podiatry Services

Services provided by a licensed podiatrist are Covered Services.

Traditional Medicaid Plan: Full coverage is limited to children up to age 21 and pregnant women. Limited podiatry benefits are covered for adults.

Non-Traditional Medicaid Plan: Limited podiatry benefits are covered.

CO-PAYMENT

Traditional Medicaid: Co-pay is $3.00 per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. Co-payment required for preventive services and immunizations.

Non-Traditional Medicaid: Co-payment is $3.00 per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

J. End Stage Renal Disease - Dialysis

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

K. Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound are Covered Services. Home health care must be rendered by a Medicare-certified Home Health Agency. The CONTRACTOR agrees to comply with all federal regulations regarding surety bonds. The CONTRACTOR agrees to contract with only Medicare-certified Home Health Agencies who carry a surety bond if federal regulations regarding this requirement are reinstated. The DEPARTMENT agrees to notify the CONTRACTOR if such federal regulations are reinstated.

Personal care services as defined in the DEPARTMENT's Medicaid Personal Care Provider Manual are included in this Contract. Personal care services may be provided by a State licensed home health agency.

L. Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are Covered Services. Hospice care must be rendered by a Medicare-certified hospice. When an Enrollee is receiving hospice in a nursing facility, ICF/MR or freestanding hospice facility, the CONTRACTOR is responsible for up to 30 days of hospice care.

M. Private Duty Nursing

Services provided by licensed nurses for ventilator-dependent children and technology-dependent adults in their home in lieu of hospitalization if Medically Necessary, feasible, and safe to be provided in the patient's home are Covered Services. Requests for continuous care will be evaluated on a case by case basis and must be approved by the CONTRACTOR.

Non-Traditional Medicaid Plan: Private Duty Nursing is not a covered service.

N. Medical Supplies and Medical Equipment

This Covered Service includes any necessary supplies and equipment used to assist the Enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the Enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but should be ordered by a physician. Durable medical equipment (DME) includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies must be provided by a DME supplier that has a surety bond. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 of the Utah Administrative Code, with the exception of criteria concerning long term care since long term care services are not covered under the Contract.

Non-Traditional Medicaid Plan excludes blood pressure monitors, and replacement of lost, damaged, or stolen durable medical equipment or prosthesis.

O. Abortions and Sterilizations

These Covered Services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements must be met regardless of whether Medicaid is primary or secondary payer.

P. Treatment for Substance Abuse and Dependency

Treatment will cover medical detoxification for alcohol or substance abuse conditions is a Covered Service. Medical services including hospital services will be provided for the medical non-psychiatric aspects of the conditions of alcohol/drug abuse.

Q. Organ Transplants

The following transplantations are Covered Services for all Enrollees: kidney, liver, cornea, bone marrow, stem cell, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, multi visceral, and combination liver/small bowel unless amended under the provisions of Attachment B, Article IV (Benefits), Section C, Subsection 2 of this Contract.

Non-Traditional Medicaid Plan is limited to kidney, liver, cornea, bone marrow, stem cell, heart, and lung transplantations.

R. Other Outside Medical Services

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

CO-PAYMENT

Traditional Medicaid: $2.00 co-payment per visit. Limited to one co-payment per date of service per provider. Annual calendar year maximum is $100.00 per Enrollee for any combination of physician, podiatry, outpatient hospital, freestanding emergency centers, and surgical centers. (Co-payment does not apply to birthing centers.)

Non-Traditional Medicaid: $3.00 co-payment per visit. Limited to one co-payment per date of service per provider. Counts toward total maximum co-payment and co-insurance of $500.00 per Enrollee per calendar year.

S. Long Term Care

The CONTRACTOR may provide long term care for Enrollees in skilled nursing facilities requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less. When the prognosis of an Enrollee indicates that long term care (over 30 days) will be required, the CONTRACTOR will notify the DEPARTMENT and the skilled nursing facility of the prognosis determination and will initiate disenrollment. Skilled nursing care is to be rendered in a skilled nursing facility which meets federal regulations of participation.

T. Services to CHEC Enrollees

1. CHEC Services

The CONTRACTOR will provide to CHEC Enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan. The CONTRACTOR is not responsible for home and community-based services available through Utah's Home and Community-Based waiver programs.

The CONTRACTOR will provide the full early and periodic screening, diagnosis, and treatment services to all eligible children and young adults up to age 21 in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels.

Non-Traditional Medicaid : CHEC services are not covered. Enrollees who are 19 or 20 years of age receive the adult scope of services.

2. CHEC Policies and Procedures

The CONTRACTOR agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules. These policies and procedures will emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC Enrollees.

U. Family Planning Services

These Covered Services includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert

with Utah law.

Birth control services include information and instructions related to the following:

1. Birth control pills;
2. Norplant (removal only);
3. Depo Provera;
4. IUDs;
5. Barrier methods including diaphragms, male and female condoms, and cervical caps;

6. Vasectomy or tubal ligations;
7. Nuvaring; and
8. Office calls, examinations or counseling related to contraceptive devices.

Non-Traditional Medicaid: Norplant is not a covered service.

V. High-Risk Prenatal Services

1. In General - Ensure Services are Appropriate and Coordinated

The CONTRACTOR must ensure that high risk pregnant Enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive, preventive, and continuous either by direct service or referral to an appropriate provider or facility. In the determination of the provider and facility to which a high risk prenatal Enrollee will be referred, care must be taken to ensure that the provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the Enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling must be made available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

2. Risk Assessment

a. General

Enrollees who are pregnant should be risk assessed at their first prenatal visit, preferably in the first trimester, and later in pregnancy as low, moderate or high risk for medical and psychosocial conditions which may contribute to poor birth outcomes. Women found to not be moderate or high risk should be evaluated for change in risk status throughout their pregnancy.

b. Assessment tools

The CONTRACTOR must have a mechanism to assure that prenatal care providers conduct risk assessments on all pregnant Enrollees on entry into prenatal care and, as needed, on an ongoing basis to re-assess risk status throughout pregnancy. Assessment tools used by prenatal care providers should be consistent with standards of practice and linked to the CONTRACTOR's care coordination/case management programs for those Enrollees who have a moderate or high risk status. All prenatal health care

providers should be able to identify the full range of medical and psychosocial risk factors and either provide appropriate care or initiate referrals to the appropriate level of care/consultation throughout pregnancy.

The CONTRACTOR's healthy pregnancy programs must also include assessment of risk for all pregnant Enrollees as soon as a pregnancy is identified and as needed, on an ongoing basis. The CONTRACTOR shall refer to and coordinate care with the prenatal care providers concerning the treatment plan and risk factors. The CONTRACTOR's risk assessments shall be overseen by the CONTRACTOR's Medical Director.

Assessment tools used by prenatal care providers and the CONTRACTOR should include a means of identifying prenatal risk factors based on medical and psychosocial conditions that may contribute to poor birth outcomes and that will assist the CONTRACTOR and prenatal care providers in determining the level and intensity of care coordination/case management required to ensure the appropriate level of perinatal care.

The DEPARTMENT recommends "Guidelines for Perinatal Care by American Academy of Pediatrics, and American College of Obstetricians and Gynecologists" as a resource for evaluating and classification of risk, the level of care and consultation recommended based on risk status, and the level of care coordination required. The DEPARTMENT recommends that Enrollees be identified with a status of no risk, low risk, moderate risk, or high risk and that at a minimum, Enrollees who are classified as moderate or high risk should receive care coordination/case management services.

c. Recommended Prenatal Screening

(1) Hepatitis B surface antigen

The DEPARTMENT recommends routine prenatal screening of every woman for hepatitis B surface antigen (HBsAg) early in prenatal care to identify all those at high risk for transmitting the virus to their newborns and later in pregnancy for women who tested negative for HbsAg during early pregnancy but who are at high risk based on:

(a) evidence of clinical hepatitis during pregnancy;
(b) injection drug use;
(c) occurrence during pregnancy or a history of STDs; or
(d) judgement of the health care provider.

When a woman is found to be HBsAg-positive, the CONTRACTOR will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life. The CONTRACTOR will comply with all other requirements as specified in Utah Law R386-702-9.

(2) Sexually Transmitted Diseases (STDs)

The DEPARTMENT recommends prenatal screening including sexually transmitted diseases such as gonorrhea, chlamydia, and standard serological testing for syphilis as required by Utah Law 26-6-20. Testing for STDs should be repeated in the 3rd trimester for Enrollees at high risk for exposure.

(3) HIV testing

The DEPARTMENT also recommends testing of all pregnant Enrollees for HIV and testing and treatment at labor and delivery for women who have not received testing during pregnancy. The CONTRACTOR should encourage providers to develop policies that are consistent with the American College of Obstetricians and Gynecologists, including but not limited to:

(a) universal testing with an opt-out approach (testing of all pregnant women and not just those who appear to be at high risk for HIV;
(b) flexibility in the consent process; and
(c) prevention and referral through education during prenatal care.

Prenatal care providers should have a mechanism to document in medical records when pregnant Enrollees are offered HIV tests and when tests are refused. Pregnant Enrollees who refuse HIV testing earlier in pregnancy should be offered HIV testing again later in pregnancy. Pregnant Enrollees who test positive should receive treatment throughout their pregnancy and labor and delivery to reduce the risk of HIV transmission to their newborns.

3. Prenatal Initiative Program

Prenatal services provided directly or through agreements with appropriate providers include those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

a. perinatal care coordination
b. prenatal and postnatal home visits
c. group prenatal and postnatal education
d. nutritional assessment and counseling
e. prenatal and postnatal psychosocial counseling

Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. This counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or mental illness should be referred to an appropriate mental health care

provider.

W. Services for Children with Special Needs

1. In General

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

2. Services Requiring Timely Access

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

a. Comprehensive evaluation for the condition.

b. Pediatric subspecialty consultation and care appropriate to the condition.
c. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.
d. Durable medical equipment appropriate for the condition.
e. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multispecialty clinics, when Medically Necessary, for their disorder.

3. Definition of Children with Special Health Care Needs

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

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

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

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

d. Inborn Metabolic Disorders such as
Phenylketonuria*
Galactosemia*

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

f. Congenital Heart Defects

g. Genetic Disorders such as
Chromosome Disorders
Genetic Disorders

h. Chronic Illnesses such as
Cystic Fibrosis
Hemophilia
Rheumatoid Arthritis
Bronchopulmonary Dysplasia
Cancer
Diabetes
Nephritis
Immune Disorders

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

The CONTRACTOR agrees to cover all Medically Necessary services for children with special health care needs such as the ones listed above. The CONTRACTOR further agrees to cooperate with the DEPARTMENT’s quality assurance monitoring for this population by providing requested information.

X. Medical and Surgical Services of a Dentist

1. Who May Provide Services

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery.

2. Universe of Covered Services

Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the Contract.

3. Services Specifically Covered

The CONTRACTOR is responsible for palliative care and pain relief for severe mouth or tooth pain in an emergency room. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital, the CONTRACTOR is responsible for coverage of the inpatient hospital stay. The CONTRACTOR is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease (excluding dental decay and periodontal disease) including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw. Also covered are injuries to sound natural teeth and associated bone and tissue resulting from accidents including services by dentists performed in facilities other than the emergency room or hospital.

4. **Dental Services Not Covered**

The CONTRACTOR is not responsible for routine dental services such as fillings, extractions, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as a surgical center or scheduled same day surgery in a hospital including the surgical facilities charges.

Y. Diabetes Education

The CONTRACTOR shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

1. has recently been diagnosed with diabetes, or

2. is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the Enrollee's self-management plan, or

3. is determined by the health care professional to require re-education or refresher training.

Z. HIV Prevention

The CONTRACTOR shall have in place the following:

1. General Program

The CONTRACTOR must have educational methods for promoting HIV prevention to Enrollees. HIV prevention information, both primary (targeted to uninfected Enrollees), as well as secondary (targeted to those Enrollees with HIV) should must be culturally and linguistically appropriate. All Enrollees should be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah State-operated programs.

2. Focused Program for Women

Special attention should be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, antiretroviral therapy during pregnancy.

SUMMARY OF CO-PAYMENT AND CO-INSURANCE REQUIREMENTS

Pregnant women and children under age 18 are exempt from all co-payment and co-insurance requirements. Services related to family planning are excluded from all co-payment and co-insurance requirements.

Traditional Medicaid Plan

- **Inpatient hospital:** Each Enrollee must pay a $220.00 co-insurance for non-emergency inpatient hospital admissions. The maximum co-payment per Enrollee per calendar year is $220.00 for non-emergency inpatient hospital admissions.

- **Emergency Department:** Each enrollee must pay a $6.00 co-payment for non-emergency use of the emergency room.

- **Physician, osteopath, podiatrist, outpatient hospital, freestanding emergency centers, and surgical centers:** Each Enrollee must pay a $3.00 co-payment per provider per day. The maximum co-payment per Enrollee per calendar year is $100.00 for any combination of the services provided by the above providers.

- **Prescription Drugs:** Each Enrollee must pay a co-payment of $3.00 per prescription. The maximum co-payment is $15.00 per Enrollee per month.*

There is no overall out-of-pocket maximum for the above services.

Non-Traditional Medicaid Plan

- **Inpatient hospital:** Each Enrollee must pay a $220.00 co-insurance for each non-emergency inpatient hospital admissions.
- **Emergency Department:** Each enrollee must pay a $6.00 co-payment for non-emergency use of the emergency room.
- **Physician, osteopath, podiatrist, physical therapist, occupational therapist, chiropractor*, freestanding emergency centers, surgical centers:** Each Enrollee must pay a $3.00 co-payment per provider per day.
- **Prescription Drugs:** Each Enrollee must pay a co-payment of $2.00 per prescription.*

The out-of-pocket maximum for each Enrollee is $500.00 for any combination of the above co-payments and co-insurance.

*Pharmacy services and chiropractic services are not the responsibility of the CONTRACTOR.

Utah's Quality Assessment and Performance Improvement Plan
(Utah "QAPIP")

For Contracted Medicaid Health Plans

Attachment D: Program Description

State of Utah
Department of Health
Division of Health Care Financing
Bureau of Managed Health Care

August 13, 2003

Utah Dept of Health

Utah Department of Health

Table of Contents

	Page
I. Utah Quality Assessment and Performance Improvement Plan (UQAPIP), Executive Summary	**3**
II. Utah Quality Assessment and Performance Improvement Plan (UQAPIP), Program Description	**4**
A. Overview	**4**
B. Purpose	**4**
C. Objectives	**4**
D. Quality Assessment and Performance Improvement (QAPI) Strategy	**5**
1. Health Plan Compliance Reviews	**5**
a. CMS Reporting	**7**
b. Documentation Requirements and Time Lines	**7**
c. Deeming	**7**
d. Corrective Actions and Sanctions	**8**
2. Internal Surveillance and Tracking (analysis of internal MMCS and Data Warehouse data)	**8**
3. External Quality Reviews (EQR's)	**8**

a. Mandatory EQR activities include **8**
b. Optional activities include **9**

4. Annual Program Evaluation Page **9**

III. Table of Appendices **10**

IV. References **11**

I. Utah Quality Assessment and Performance Improvement Monitoring Plan (QAPIP) Executive Summary:

The Utah Department of Health (DOH), Division of Health Care Financing (DHCF), Bureau of Managed Health Care (BMHC) by authority of 42 CFR, Part 438, Subparts C, D, E, F, H (438.602, 438.608, 438.610), and Subpart I (438.700) has oversight responsibility of contracted Medicaid health plans to ensure the delivery of quality health care and compliance with state and federal regulations.

The BMHC oversight methodology consists of activities to collect and analyze data from on-site reviews, required reports, and other internal and external data sources. This information is used to determine compliance with state Medicaid requirements; federal regulations pertaining to managed care entities; to identify opportunities for improvement and areas of non-compliance. When BMHC identifies non-compliance and areas where improvement is needed, BMHC makes recommendations and requires corrective action plans (CAP's). Health plans are required to submit CAP's according to specified timeframes; BMHC reviews what is submitted and either accepts or requests a revised CAP. Health plans can request extensions to the required CAP timeframes or appeal the BMHC's findings. Once the health plan submits an acceptable action plan, the BMHC provides adequate opportunity for the plan to implement corrections and improvements. Follow up activities are conducted thereafter to assess progress toward compliance and address areas for continuous improvement.

The BMHC uses information from quality monitoring activities to assess the effectiveness of its monitoring program, implement improvements to its oversight processes, update health plan compliance requirements and develop work plans for subsequent years. The BMHC reports to Centers for Medicare and Medicaid Services (CMS) as required concerning results of quality monitoring activities and program evaluations.

II. Utah Quality Assessment and Performance Improvement Monitoring Plan (QAPIP) Program Description

A. Overview:

The Utah Department of Health (DOH), Division of Health Care Financing (DHCF), Bureau of Managed Health Care (BMHC) by authority of 42 CFR, Part 438, Subparts C, D, E, F, H (438.602, 438.608, 438.610), and Subpart I (438.700) has oversight responsibility of contracted Medicaid health plans to ensure the delivery of quality health care and compliance with state and federal regulations.

The UTAH QAPIP encompasses oversight of regulations pertaining to Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs) and Primary Care Case Management (PCCM) entities.

B. Purpose:

The purpose of the Utah Quality Assessment and Performance Improvement Plan is to ensure that the Medicaid health plans provide quality health care to Medicaid enrollees, to provide a mechanism to ensure continuous improvement in the care and services provided and assess compliance to state and federal regulations required for managed care entities.

C. Objectives:

- To establish a monitoring plan that uses experts outside of the BMHC to promote interagency cooperation and support other state DOH programs.
- To establish a monitoring plan which includes deeming provisions, in order to minimize duplication and redundancy of comparable monitoring content for organizations that have received accreditation by a nationally recognized accreditation body.
- To assess the quality, availability and access to, coordination of, and appropriateness of care and services provided to Medicaid enrollees (including those with special health care needs) under MCO, PIHP and PCCM contracts.
- To assure care and services are provided in a culturally competent manner, which respects the rights of enrollees, including those with disabilities.
- To assess compliance through regular monitoring in a way that promotes collaboration and continuous quality improvement.
- To ensure adherence to contract requirements, state and federal regulations applicable to the types of health plans contracted with Medicaid.
- To assure appropriate adherence to privacy and confidentiality rules in the provision of care and services.
- To assure the organizations structure, operations and information systems support adherence to the Utah QAPIP, program oversight needs and meet federal and state regulations.
- To assure that data and documentation necessary for quality oversight is accurate and complete.

D. Quality Assessment and Performance Improvement (QAPI) Strategy:

The BMHC's methods of oversight of contracted Medicaid health plans involve an integrated approach using information derived from the following four activities. These include:

1. **Health Plan Compliance Reviews**
2. **Internal Surveillance and Tracking (analysis of internal data)**
3. **External Quality Review (EQR)**
4. **Annual Program Review**

1. Health Plan Compliance Reviews

The BMHC conducts periodic reviews of contracted MCOs, PIHPs and PCCMs to monitor contract compliance and compliance to state and federal regulations applicable to these types of health plan entities. Reviews are done using the Utah Quality Assessment and Performance Improvement Plan (QAPIP), which is a comprehensive set of compliance Standards based on quality improvement, contract monitoring, and regulatory oversight needs. Most of the compliance Standards in the QAPIP is applicable to MCO and PIHP health plan entities. Oversight of PCCM contracts and compliance with state and federal regulations is also accomplished through the UTAH QAPIP; although, much fewer of the compliance Standards are applicable to PCCM entities.

The BMHC's conducts periodic comprehensive quality monitoring reviews (CQMRs) using the UTAH QAPIP compliance Standards. Frequency of CQMRs is determined by the level of compliance demonstrated during the on-reviews, internal surveillance and monitoring (number 2, described below), the amount of structural or operational changes made following reviews or based on other oversight needs. For all MCO or PIHP entities CQMR's will occur at least every threes years and more frequently when necessary. Annually, follow-up reviews will be done to assess progress toward recommended improvements and CAPs. The BMHC may also conduct a focused review of a particular area(s); these are Follow-up/ Focused Quality Monitoring Review's (FQMR's).

CQMRs consist of review of all UTAH QAPIP pertaining to the type of entity being reviewed and all applicable data sources for each area. The UTAH QAPIP delineates compliance areas that require detailed program narratives, any mandatory data sources needed to assess compliance, authority for particular areas of compliance, applicability of deeming status for entities who have received national accreditation, and DOH staff resources that may be used to assess each compliance area. Documentation requirements for annual monitoring will be tailored to the level of compliance from the most recent CQMR, analysis from internal surveillance, and other monitoring needed relating to quality, access to care and appropriateness of care and services, etc.

CQMRs for MCOs or PIHPs will occur "on-site" at the organization's local office(s). On-site reviews will consist of reviewing documentation, interviewing staff and conducting an exit conferencing, which outlines the organization's strengths and weaknesses. The BMHC may use on-site review, in-person meetings or teleconferencing to conduct

FQMRs. For PCCMs, an assessment of compliance to applicable regulations may be conducted less formally (telephone conference following review of applicable documentation) and therefore not require an on-site review. The BMHC's Quality Monitoring Unit staff and other DOH consultants will participate in review activities. The BMHC uses consultants from the Division of Community and Family Health Services, the Office of Health Care Statistics and other DHCF staff to conduct reviews.

Following each review, the BMHC will compile a report addressing the level of compliance to applicable Utah QAPIP Standards for the type of entity being reviewed. This report will detail findings, recommendations for improvements and general comments. Written corrective action plans (CAPs) for any areas of non-compliance will be required as necessary. The BMHC will conduct follow-up reviews annually that will assess the plan's progress toward CAPs, other recommended improvements and monitoring related to reviews and any reports required by the contract relating to quality, access to care and appropriateness of care and services since the last review. Depending on the level of compliance, BMHC may elect to repeat CQMR as often as necessary or conduct a partial/focused review annually until the required level of compliance is achieved. Quarterly progress reports (verbal or written) may be required depending on the level of non-compliance determined from CQMR or FQMRs.

The BMHC will regularly monitor areas requiring annual oversight (see compliance Standards for "crosswalk" of annual monitoring areas). Attestation statements may be permitted to satisfy part(s) of the QAPIP compliance areas after a sufficient level of performance is demonstrated through CQMR's. Attestation statements are permitted only for areas that have not changed or have changed minimally since the last review. The BMHC will determine if the attestations are acceptable on a case-by-case basis. These will permit the health plan to not have to provide full program narratives for areas that have not changed since the last review or have changed minimally. The BMHC will determine if attestations are acceptable on a case-by-case basis.

Annually, Medicaid MCOs and PIHPs are required to produce a Work Plan (WP) each new calendar year detailing all quality assessment and performance improvement (QAPI) activities; including activities related to recommended improvements from reviews/CAPs, the organization's clinical and non clinical performance improvement projects/studies, specific program activities, projects related to priority population groups, federal or state requirements, etc. Additionally, on completion of each calendar year the health plans are required to conduct a comprehensive program evaluation, called a Work Plan Evaluation (WPE), to determine the effectiveness of interventions in each area of the WP. The WPE is expected to be part of the process used to develop the WP for each new year and update the organizations overall Quality Improvement Program Description (QIPD), if necessary.

The BMHC on an ongoing basis will provide input on WP, WPE and annually updated QIPD's as part of annual monitoring activities or reviews for MCOs and PIHPs. PCCMs are not required to submit these documents since they are outside the scope of their regulations; however, may be required to submit other annual reports related to applicable regulations or compliance areas.

a. Center for Medicare and Medicaid Services (CMS) Reporting:

In accordance with 42 CFR, part 438, 438.202, the BMHC will submit to CMS any required repots relating to BMHC's UAPIP/quality improvement (QI) strategy, reports on the implementation and effectiveness of the QAPIP/QI strategy and of updates whenever substantial changes to the UAPIP/QI strategy are made. Additionally, CMS may require the BMHC to submit reports of findings from compliance reviews and EQR's.

b. Documentation Requirements and Timelines:

Each health plan will be required to submit documentation that specifically addresses all compliance Standards in the QAPIP prior to a CQMR and FQMR. This documentation is required to be organized and categorized in accordance with the sequencing of each domain and Standard within the Utah QAPIP. Process narratives (a description of the compliance area and how compliance is achieved) are mandatory for specific areas in which exhibits alone are insufficient to determine how the plan operates in the given area (see "crosswalk" section of compliance Standards).

Prior to an audit, the health plan may be required to submit pre-review documentation as early as 60 days before a CQMR or FQMR. All documentation is required to be available during the entire time of an on-site review. Organization's being reviewed are required to provide suitable, private workspace; i.e., private conference room with a phone, for the number of staff participating and make appropriate plan staff available to assist in finding necessary information during documentation review sessions or for answering questions. Prior to a CQMR or FQMR an agenda will be developed including time frames for reviewing documentation, interviews, post interview team consultation and an exit conference.

Following a CQMR or FQMR the BMHC will complete a compliance report within 60 calendar days of the date of the exit conference. The health plans, if necessary, will be required to submit a written plan of correction within 45 calendar days of the receipt of the compliance report or submit an appeal of the BMHC's findings. If an extension is required the organization may request, in writing, an extension to the due date for the CAP and the timeframes will be adjusted as appropriate. The BMHC will provide written approval as to the acceptance of the CAP within 30 calendar days of BMHC's receipt of the CAP. Within 30 calendar days of the receipt of the CAP the BMHC will provide written approval or request revisions, if not accepted.

c. Deeming:

The BMHC has incorporated deeming provisions in the UTAH QAPIP for areas applicable to MCOs and PIHPs. Accreditation by a nationally recognized accreditation agency that is also recognized by the State will be accepted to fulfill some compliance requirements. Examples of nationally recognized accreditation agencies include National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Utilization Review and Accreditation Commission (URAC), also known as American Accreditation HealthCare Commission. The organization must provide written verification of accreditation in areas where deeming may be applicable. The BMHC will determine areas applicable for deeming based on comparability and level of accreditation achieved.

d. Corrective Actions and Sanctions:

Corrective actions may be required to be submitted relating to quality monitoring activities if the BMHC determines the contracted Medicaid organization has not provided services in accordance with the contract or within expected professional standards. The BMHC will request in writing that the health plan correct deficiencies or identified problems through a corrective action plan (CAP). The contracted Medicaid health plan agrees with all applicable procedures and time frames set forth in the contract regarding compliance with CAP's. However, CAP's which are the result of non compliance findings with the Utah QAPIP, following reviews, longer time frames are granted for submitting initial CAP's and subsequent requests for revision to CAP's, until final acceptance. Additionally, longer time frames may be granted prior to implementing sanctions. Areas of non compliance related to contract requirements or the UQAMP, which are deemed more critical or urgent, may be subject to time frames associated with requests for CAP's as set forth in the contract. The BMHC will follow do-process procedures as outlined in the contract with regard to requests for CAP's, requests for extensions of CAP's, allowing opportunity to appeal findings, considering explanations of disagreement and in issuing hearing rights.

2. Internal Surveillance and Tracking (analysis of internal MMCS and Data Warehouse data)

Additionally, as a mechanism of quality oversight the BMHC will monitor and analyze other available internal data. These include internal MMCS data; information available through the state's Data Warehouse or reported encounter data. When possible and appropriate this information will be integrated into compliance reviews in order to address areas where further study or improvement may be needed or when additional information is needed.

3. External Quality Reviews (EQR's):

The BMHC uses an External Quality Review Organization (EQRO) to conduct an annual, external assessment of outcomes related to quality, access to and timeliness of care for services covered in MCO and PIHPs contracts (42 CFR Part 438, Subpart E, 438.320). External review includes mandatory and optional activities.

Mandatory EQR activities include using information from the following activities:

1. Validation of performance improvement projects as noted in 438.240(b)(1), validation of performance measures required by the state in accordance with 438.240(b)(2), and

2. To conduct a review within the previous 3 year period to determine MCO's or PIHP's compliance with standards related to access to care, structure and operations, and quality measurement [(438.204(g)].

Optional activities include using information derived from the previous 12 months from the following activities:

1. Validation of encounter data reported by an MCO or PIHP,
2. Administration or validation of consumer or provider surveys of quality of care,
3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validation
4. Conducting performance improvement projects in addition to those conducted by an MCO or PIHP.

The BMHC assures that EQROs meet the qualifications to perform external quality reviews (EQRs) as set forth in 42 CFR, Part 438, Subpart E, 438.354 (competence and independence). The state, its agent or the EQRO may perform the mandatory and optional EQR-related activities [42 CFR, Part 438, Subpart E, 438.358(a)].

The BMHC will assure that the date collection methods and tools used by the EQRO are consistent with the Medicaid managed care provisions of the Balanced Budget Act (BBA) and the compliance requirements outlined in the Utah QAPIP, which were developed to assess compliance in accordance with the BBA.

The EQRO will submit reports in accordance with requirements in 438.364. The BMHC will make available upon request information obtained from the technical report supplied by the EQRO to interested parties, such as participating health care providers, enrollees and potential enrollees of the MCO or PIHP, recipient advocacy groups and general public. This information will be supplied in alternative formats for persons with sensory impairments, when requested.

The EQRO contract may be amended as necessary in order to accommodate review activities. Study subjects will be determined collaboratively by DHCF, BMHC, EQRO and health plan staff.

4. Annual Program Evaluation

Annually, the BMHC will develop a Work Plan, which outlines the planned review activity (CQMR or follow up reviews), EQR activity and activities related to available systems data (MMCS/DW, grievance/appeals, hearings, exemptions, reporting, etc.,). At the end of each calendar a Work Plan Evaluation will be completed. The Work Plan Evaluation will be used to develop the Work Plan for each new year and schedule monitoring reviews. At least every 3 years the BMHC will perform a more comprehensive evaluation, which will be used to make program improvements. The BMHC will submit to CMS any required reports relating to the states quality improvement program.

III. Table of Appendices

Tab Heading	Content
Utah's QAPIP	Utah's Quality Assessment and Performance Improvement Monitoring Plan (Program Description Document)
Table of Appendices	Listing of all appendices to Attachment G, Utah's QAPIP
Appendix A Flow Chart	Utah QAPIP Flow Chart
Appendix B Crosswalk	(B1) Utah's QAPIP Compliance Standards Crosswalk (DRAFT) (B2) Federal Register
Appendix C Definitions	Definitions
Appendix D Scoring	Weighting and Scoring (to be developed)
Appendix E Attestation	Attestation Template (to be developed)
Appendix F Data Collection	Review Data Collection Tools
Appendix G WP Format	Work Plan Format (required)
Appendix H WPE Format	Work Plan Format (required)
Appendix I PI Topics	(I1) Example Clinical and Non-Clinical Areas for Study (I2) Example Performance Improvement (PI) Project Description

Appendix J CM Report	Example Case Management Report
Appendix K ACOG Record	Example Risk Assessment Information: ACOG Antepartum Record© (by permission of Donna Weber, ACOG Marketing, Inventory and Distribution Manager, July 1, 2003)
Appendix L	Example CHEC Audit Report
Appendix M	(M1) Example Grievance, Appeal, Action and Notice of Action Requirements (M2) Example Grievance Tracking (M3) Flow Charts for Grievances, Appeals, Actions, Notices of Action, Continuation of Benefits and State Fair Hearing Procedures
Appendix N	Example Newsletter Topic Tracking Grid
Appendix O	Priority Matrix
Appendix P	Member Handbook Checklist (DRAFT)

IV. References

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Attachment E
Healthy U

MEDICAL SERVICES REVENUE AND COST DEFINITIONS FOR TABLE 2

REVENUES (Report all revenues received or receivable at the end-of-period date on the form)

1. Premiums

Report premium payments received or receivable from the DEPARTMENT.

2. Delivery Fees

Report the delivery fee received or receivable from the DEPARTMENT.

3. Reinsurance

Report the reinsurance payments received or receivable from a reinsurance carrier other than the DEPARTMENT.

4. Stop Loss

Report stop loss payments received or receivable from the DEPARTMENT.

5. TPL Collections - Medicare

Report all third party collections received from Medicare.

6. TPL Collections - Other

Report all third party collections received other than Medicare collections. (Report TPL savings because of cost avoidance as a memo amount on line 48).

7. Other (specify)

8. Other (specify)

For lines seven and eight: Report all other revenue not included in lines one through six. (There may not be any amount to report; however, this line can be used to report revenue from total Utah operations that do not fit lines one through six.)

9. **TOTAL REVENUES**

Total lines one through eight.

NOTE: Duplicate premiums are not considered a cost or revenue as they are collected by the CONTRACTOR and paid to the DEPARTMENT. Therefore, the payment to the DEPARTMENT would reduce or offset the revenue recorded when the duplicate premium was received. However, line 49 has been established for reporting duplicate premiums as a memo amount.

MEDICAL COSTS: Report all costs accrued as of the ending date on the form. In the first data column (column 3), report all costs for Utah operations per the general ledger. In the 15 Medicaid data columns (columns 4 through 18), report only costs for Medicaid Enrollees.

10. Inpatient Hospital Services

Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.

11. Outpatient Hospital Services

Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.

12. Emergency Department Services

Costs incurred in providing outpatient hospital emergency room services to Enrollees.

13. Primary Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred for Enrollees as a result of providing primary care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

14. Specialty Care Physician Services (Including EPSDT Services, Prenatal Care, and Family Planning Services)

All costs incurred as a result of providing specialty care physician, osteopath, physician assistant, nurse practitioner, and nurse midwife services to Enrollees, including payroll expenses, any capitation and/or contract payments, fee-for-service payments, fringe benefits, travel and office supplies.

15. Adult Screening Services

Expenses associated with providing screening services to Enrollees.

16. Vision Care - Optometric Services

Included are payroll costs, any capitation and/or contract payments, and fee-for-service payments for services and procedures performed by an optometrist and other non-payroll expenses directly related to providing optometric services for Enrollees.

17. Vision Care - Optical Services

Included are payroll costs, any capitation and/or contract payments and fee-for-service payments for services and procedures performed by an optician and other supportive staff, cost of eyeglass frames and lenses and other non-payroll expenses directly related to providing optical services for Enrollees.

18. Laboratory (Pathology) Services

Costs incurred as a result of providing pathological tests or services to Enrollees including payroll expenses, any capitation and/or contract payments, fee-for-service payments and other expenses directly related to in-house laboratory services. Excluded are costs associated with a hospital visit.

19. Radiology Services

Cost incurred in providing x-ray services to Enrollees, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-service payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

20. Physical and Occupational Therapy

Included are payroll costs, any capitation and/or contract payments, fee-for-service costs, and other non-payroll expenditures directly related to providing physical and occupational therapy services.

21. Speech and Hearing Services

Payroll costs, any capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing speech and hearing services for Enrollees.

22. Podiatry Services

Salary expenses or outside claims, capitation and/or contract payments, fee-for-service payments, and non-payroll costs directly related to providing services rendered by a podiatrist to Enrollees.

23. End Stage Renal Disease (ESRD) Services - Dialysis

Costs incurred in providing renal dialysis (ESRD) services to Enrollees.

24. Home Health Services

Included are payroll costs, any capitation and/or contract payments, fee-for-service payments, and other non-payroll expenses directly related to providing home health services for Enrollees.

25. Hospice Services

Expenses related to hospice care for Enrollees including home care, general inpatient care for Enrollees suffering terminal illness and inpatient respite care for caregivers of Enrollees suffering terminal illness.

26. Private Duty Nursing

Expenses associated with private duty nursing for Enrollees.

27. Medical Supplies and Medical Equipment

This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by the CONTRACTOR to Enrollees.

28. Abortions

Medical and hospital costs incurred in providing abortions for Enrollees.

29. Sterilizations

Medical and hospital costs incurred in providing sterilizations for Enrollees.

30. Detoxification

Medical and hospital costs incurred in providing treatment for substance abuse and dependency (detoxification) for Enrollees.

31. Organ Transplants

Medical and hospital costs incurred in providing transplants for Enrollees.

32. Other Outside Medical Services

The costs for specialized testing and outpatient surgical centers for Enrollees ordered by the CONTRACTOR.

33. Long Term Care

Costs incurred in providing long-term care for Enrollees required under Attachment C.

34. Transportation Services

Costs incurred in providing ambulance (ground and air) services for Enrollees.

35. Accrued Costs

Costs Incurred for services rendered to Enrollees but not yet billed.

36/37 Other

Report costs not otherwise reported.

38. **TOTAL MEDICAL COSTS**

Total lines10 through 37.

ADMINISTRATIVE COSTS

Report payroll costs, any capitation and/or contract payments, non-payroll costs and occupancy overhead costs for accounting services, claims processing services, health plan services, data processing services, purchasing, personnel, Medicaid marketing and regional administration.

Report the administration cost under four categories - advertising, home office indirect cost allocation, utilization and all other administrative costs. If there are no advertising costs or indirect home office cost allocations, report a zero amount in the applicable lines.

39. Administration - Advertising

40. Home Office Indirect Cost Allocations

41. Utilization

Payroll cost and any capitation and/or contract payments for utilization staff and other non-payroll costs directly associated with controlling and monitoring outside physician referral and hospital admission and discharges of Enrollees.

42. Administration - Other

43. **TOTAL ADMINISTRATIVE COSTS**

Total lines 39 through 42.

44. **TOTAL COSTS (Medical and Administrative)**

Total lines 38 and 43.

45. **NET INCOME (Gain or Loss)**

Line 9 minus line 44.

46. **ENROLLEE MONTHS**

Total Enrollee months for period of time being reported.

47. **MEDICAL COSTS PER ENROLLEE MONTH**

Line 38 divided by line 46.

48. **ADMINISTRATIVE COSTS PER ENROLLEE MONTH**

Line 43 divided by line 46.

49. **TOTAL COSTS PER ENROLLEE MONTH**

Line 44 divided by line 46.

OTHER DATA

50. TPL Savings - Cost Avoidance

51. Duplicate Premiums

Include all premiums received for Enrollees from all sources other than Medicaid.

52. Number of Deliveries

Total number of Enrollee deliveries when the delivery occurred at 24 weeks or later.

53. Family Planning Services

Include costs associated with family planning services as defined in Attachment C (Covered Services, Section V, Family Planning Services).

54. Reinsurance Premiums Received

Include the reinsurance premiums received or receivable that are not counted as revenue.

55. Reinsurance Premiums Paid

Include reinsurance premiums paid to a reinsurance carrier other than the DEPARTMENT.

56. Administrative Revenue Retained by the CONTRACTOR

Include the administrative revenue retained by the CONTRACTOR from the reinsurance premiums received or receivable.

MEDICAL SERVICES UTILIZATION DEFINITIONS FOR TABLE 3

MEDICAL SERVICES

1. Hospital Services - General Days

Record total number of inpatient hospital days associated with inpatient medical care.

2. Hospital Services - Discharges

Record total number of inpatient hospital discharges.

3. Hospital Services - Outpatient Visits

Record total number of outpatient visits.

4. Emergency Department Visits

Record total number of emergency room visits.

5. Primary Care Physician Services

Number of services and procedures defined by CPT-4 codes provided by primary care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/ immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

6. Specialty Care Physician Services

Number of ser services and procedures defined by CPT-4 codes provided by specialty care physicians or licensed physician extenders or assistants under direct supervision of a physician inclusive of all services except radiology, laboratory and injections/ immunizations which should be reported in their appropriate section. The reporting of data under this category includes both outpatient and inpatient services.

7. Adult Screening Services

Number of adult screenings performed.

8. Vision Care - Optometric Services

Number of optometric services and procedures performed by an optometrist.

9. Vision Care - Optical Services

Number of eye glasses and contact lenses dispensed.

10. Laboratory (Pathology) Procedures

Number of procedures defined by CPT-4 Codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

11. Radiology Procedures

Number of procedures defined by CPT-4 Codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.

12. Physical and Occupational Therapy Services

Physical therapy refers to physical and occupational therapy services and procedures performed by a physician or physical therapist.

13. Speech and Hearing Services

Number of services and procedures.

14. Podiatry Services

Number of services and procedures.

15. End Stage Renal Disease (ESRD) Services - Dialysis

Number of ESRD procedures provided upon referral.

16. Home Health Services

Number of home health visits, such as skilled nursing, home health aide, and personal care aide visits.

17. Hospice Days

Number of days hospice care is provided, including respite care.

18. Private Duty Nursing Services

Hours of skilled care delivered.

19. Medical Supplies and Medical Equipment

Durable medical equipment such as wheelchairs, hearing aids, etc., and nondurable supplies such as oxygen etc.

20. Abortion Procedures

Number of procedures performed.

21. Sterilization Procedures

Number of procedures performed.

22. Detoxification Days

Days of inpatient detoxification.

23. Organ Transplants

Number of transplants.

24. Other Outside Medical Services

Specialized testing and outpatient surgical services ordered by IHC.

25. Long Term Care Facility Days

Total days associated with long-term care.

26. Transportation Trips

Number of ambulance trips.

27. Other (specify)

Attachment F
Molina Healthcare of Utah
January 1, 2006

MOLINA
Attachment F: Payment Methodology

This Contract is classified as non-risk. Under a non-risk contract, the DEPARTMENT's total payments to Molina for medical services provided under this Contract net of third party payments may not exceed the Payment Limit. The Payment Limit is the total amount Medicaid would have paid for the same services on a fee-for-service (FFS) basis net of third party payments. In calculating payments, the DEPARTMENT will use its reimbursement schedule for each claim and subtract any third party payment reported on each claim to determine the amount the DEPARTMENT pays on each claim.

Molina may reimburse individual providers at rates different from the Medicaid fee schedule. However, the DEPARTMENT's aggregate payments to Molina for medical services provided to its Enrollees must not exceed what Medicaid would have paid in aggregate for the same services on a FFS basis.

Based on direction from the Centers for Medicare and Medicaid Services (CMS), the 9% add-on amount that the DEPARTMENT reimburses Molina that includes administration, case management services, profit earned, etc., and any incentive payments (CHEC screenings and immunizations) will not be included when determining the total payments the DEPARTMENT paid Molina when ascertaining compliance with the Payment Limit for a non-risk contract. The amount for administration, case management services, and profit that the DEPARTMENT reimburses Molina will be included when calculating the savings sharing payments. If CMS requires in writing that this method of calculating the Payment Limit be revised, this Contract will be amended in accordance with, and only to the extent necessary to comply with, the specific requirements of CMS.

For Molina clients enrolled in Molina's Medicare product, Molina will reimburse its providers at no less than the Medicare fee schedule.

A. Molina Cost Plus 9% Payment Provisions Based on Molina's Encounter Records

1. Molina will submit encounter records to the DEPARTMENT following the Electronic Data Interchange (EDI) standards defined in the *Encounter Records 837 Institutional Companion Guide* and *Encounter Records 837 Professional Companion Guide*. Molina will not submit any encounter record in the same month in which the service to which the encounter record relates was provided. In the event Molina inadvertently does so, the DEPARTMENT will not pay for any encounter record in the same month in which the service was provided.

2. The DEPARTMENT will process Molina's encounter records and reimburse Molina for encounter records that pass the Medicaid Managed Care System (MMCS) encounter records' edits within 30 calendar days

after the DEPARTMENT has received the encounter records. However, it is the intent of the DEPARTMENT to pay Molina within 15 calendar days after the DEPARTMENT has received the encounter records. The DEPARTMENT will reimburse Molina the amount Molina paid its providers as reflected in each encounter record's "paid amount" field, net of third party payments, for those encounters that pass the MMCS edits. In addition, the DEPARTMENT will pay to Molina an additional amount equal to 9% of the total amount of paid encounter records, net of third party payments. The 9% does not apply to the Medicaid payment on encounters for Molina's Medicaid enrollees who are also enrolled in Molina's Medicare plan.

3. The 9% is based on the reasonable expenses of managed care plans organizations for all administrative functions, case management services, profit earned, etc. necessary to operate as an efficient and effective Medicaid managed care plan and including federal managed care requirements as described in 42 CFR Part 438–Managed Care. The DEPARTMENT will verify Molina's costs incurred for administration, case management services, profit earned, etc. using the quarterly reports submitted by Molina as defined in Section F., Quarterly Report of Costs Incurred for Administration, Case Management Services, Etc., of this

Attachment F.

4. Rejected encounter records that are corrected and resubmitted and that clear the MMCS edits will be paid to Molina in the next regular payment cycle.

B. Savings Sharing Provision for FY2005 and FY2006

1. **Summary of Savings Sharing Methodology**

For State fiscal years 2005 and 2006, the DEPARTMENT will calculate the amount due to Molina, if any, under this Savings Sharing Provision, utilizing both a "risk-adjuster" methodology and a "fee-for-service methodology." The DEPARTMENT will first apply the risk-adjuster methodology. The DEPARTMENT will next apply the "fee-for-service" methodology to determine the Payment Limit. Molina will be entitled to the greater of the two savings amounts from the two calculation methods as a savings incentive payment. Under no circumstances will the DEPARTMENT pay Molina for both savings sharing calculations and in no event shall the savings sharing payment exceed 95% of the Payment Limit.

a. If one or both of the PMPM urban and rural member calculations show that Molina's risk adjusted aggregate PMPM cost for FY2005

and/or FY2006 are less than that of the IHC Access enrollees and/or FFS rural enrollees respectively, then the DEPARTMENT will pay to Molina either ninety-five percent (95%) of the aggregate savings amount up to 95% of the Payment Limit or 75% of the savings calculated in Section B.2.c., whichever is greater.

b. If the PMPM urban and rural calculation show that Molina's risk adjusted aggregate PMPM costs for State FY2005 or FY2006 are greater than that of IHC Access urban enrollees or FFS rural for the same period, then the DEPARTMENT will pay Molina either nothing or 75% of the savings calculated in Section B.2.c (subject to Section B.1.a. above regarding the greater of 95% of the Payment Limit and 75% of the risk adjusted amount).

2. Risk-Adjuster Methodology

The same calculations described below for Molina's urban enrollees will be used for Molina's rural enrollees. The same calculations described below for IHC Access urban enrollees will be used for fee-for-service rural clients except where noted.

The DEPARTMENT will calculate Molina's risk adjusted, aggregate per member per month (PMPM) cost for State fiscal years 2005 and 2006 for Molina's urban -members and compare the PMPM cost against IHC Access urban enrollees for the same time periods. The PMPM amount paid to Molina's urban enrollees is the cost of claims plus a 9% add-on fee for administration, case management services, profit earned, etc. The PMPM amount the DEPARTMENT would have paid for IHC's urban enrollees is the Medicaid fee schedule plus a 2% administration fee plus the IHC network access and continuum care case management fees.

The PMPM amount paid to Molina's rural enrollees is the cost of claims plus a 9% add-on fee for administration, case management services, profit earned, etc. The PMPM amount the DEPARTMENT would have paid is the Medicaid fee schedule for rural fee-for-service Medicaid clients plus a 2% administration fee.

In performing the PMPM calculation, the DEPARTMENT will share with Molina, subject to appropriate confidentiality agreements, all data, methodologies, and assumptions used in the PMPM calculations, and shall afford Molina a reasonable opportunity to review and comment regarding such data, methodologies, assumptions and report, and to confer with and ask questions of the actuary who performed the calculations and prepared the report.

The DEPARTMENT will use an independent actuary to measure cost effectiveness for determining any savings sharing as follows:

a. The actuary will select a comparable fee-for-service Medicaid population to compare with the Molina's managed care population. IHC Access (IHC) urban enrollees will be the comparable plan for Molina's urban enrollees. Fee-for-service rural clients will be the comparable population for Molina's rural enrollees.

b. The actuary will compare expenditures for Molina urban enrollees with IHC Access urban enrollees by dates of service and eligibility for the same year as the Contract year.

c. The items to be compared are as follows:

(1) Claims Expenditures *Without* Third Party Payment

These expenditures represent the total dollars that the DEPARTMENT paid to health plans. For Molina the expenditures are the amount pursuant to Section A. less expenditures the DEPARTMENT paid to Molina for Enrollees who are "dual eligible" (have both Medicare and Medicaid). For IHC, the expenditures include those claims the DEPARTMENT paid for IHC enrollees under Medicaid's fee-for service system less 1) expenditures the DEPARTMENT paid for IHC dual eligibles, and 2) any amounts the DEPARTMENT paid for IHC enrollees with dates of service during any period when an IHC enrollees was retroactively eligible for Medicaid. The actuary will summarize the total dollar amounts by rate cell for Molina and IHC.

(2) Claims Expenditures *With* Third Party Payment

These expenditures represent the total dollars which would have been allowed under the Medicaid fee schedule to health plans and the dollar figure used to calculate the per member per month expenditure. For Molina, the expenditures are the amount pursuant to Section A. less expenditures the DEPARTMENT paid to Molina for Enrollees who are "dual eligible" (have both Medicare and Medicaid). For IHC, the expenditures include those claims the Department paid for IHC enrollees under Medicaid's fee-for service system less 1) expenditures the DEPARTMENT paid for IHC dual eligibles, and 2) any amounts the

DEPARTMENT paid for IHC enrollees with dates of service during any period when an IHC enrollee was retroactively eligible for Medicaid. The actuary will summarize the total dollar amounts by rate cell for Molina and IHC.

(3) Eligibles

For Molina and IHC, the actuary determines the total number of eligibles by rate cell (excluding retroactive eligibles and dual eligibles) for each month of the Contract year for Molina and for IHC. Total member months by rate cell are calculated for Molina and for IHC by adding all months by rate cell.

(4) Raw Per Member Per Month (PMPM) Calculation

The actuary calculates a raw PMPM rate by dividing the "claims expenditures with third party payment" by the number of member months. This is done for each rate cell as well as total expenditures and total member months. The calculation includes an eligibility group mix factor that normalizes the raw calculation for eligibility group mix.

(5) Risk Adjuster

The actuary calculates a risk adjuster from the diagnosis data used in the expenditure totals. These diagnosis data are applied to a risk adjuster methodology that is accepted and used nationally. The resulting risk adjuster shows the relative complexity of each health plan's cases to each other. The risk adjuster excludes lab and x-ray and uses a population-normalized risk adjustment factor. The resulting numbers are a separate risk adjuster by rate cell for each of the plans compared. The composite risk adjustment scores are calculated using all plans enrollment distribution and PMPM costs relativity.

(6) Per Member Per Month calculation (risk and eligibility mix adjusted)

This calculation is made by dividing the raw PMPM calculation by the risk adjuster.

(7) Administrative Cost /Adjustment

This adjustment is a PMPM amount by rate cell to account for administrative costs. Molina's adjustment is the 9% for administration, case management services, and profit that is an add-on to the cost of claims expenditure ("Claims Expenditures *Without* Third Party Payment") that Molina

receives as part of its contract. IHC's adjustment is the administrative add-on includes the network access and continuum care case management fees; plus the 2% administration fee. The rural fee-for-service's adjustment is the 2% administration fee.

(8) Other Adjustments

These rate cell amounts are the amount added or subtracted to account for items outside claims processing such as Synagis or other special drugs.

(9) Total Adjustments

Administrative Cost and Other Adjustments added together and then calculated on a PMPM adjustment value.

(10) Combined PMPM Risk Adjusted Claims Expenditure and Adjustment

This final number adds the "PMPM Calculation (Risk and Eligibility Mix Adjusted)" and the "Total Adjustments" PMPM to give a final comparison number.

d. If Molina's "Combined Urban PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c.(10) amount is greater than IHC's "Combined Urban PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c. (10), then a cost savings has not occurred and Molina is not eligible for a savings sharing payment for urban claims under this risk-adjuster methodology.

If Molina's "Combined Rural PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c.(10) amount is greater than the fee-for-service "Combined Rural PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c.(10), then a cost savings has not occurred and Molina is not eligible for a savings sharing payment for rural claims under this risk-adjuster methodology.

e. If Molina's "Combined Urban PMPM Risk Adjusted Claims Expenditure and Adjustment" amount is less than IHC's "Combined Urban PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c.(10), then a cost savings has occurred and Molina is eligible for a savings sharing payment for urban

claims under this risk-adjuster methodology .

If Molina's "Combined Rural PMPM Risk Adjusted Claims Expenditure and Adjustment" amount is less than the fee-for-service rural "Combined Rural PMPM Risk Adjusted Claims Expenditure and Adjustment" pursuant to Section B.2.c.(10), then a cost savings has occurred and Molina is eligible for a savings sharing payment under this risk-adjuster methodology.

3. Payment Limit Methodology

a. Determination of Covered Encounters

All encounter records not rejected in the process under Section A. above will go through a final cleansing by running said encounters through the DEPARTMENT's fee-for-service process. Encounters for which the DEPARTMENT paid the CONTRACTOR under Section A. but that are not covered encounters based on the criteria in B.3.b. will be excluded from the Payment Limit calculation.

The DEPARTMENT will provide documentary support for its calculation to Molina and afford Molina a reasonable opportunity to review and comment.

b**. Covered Services Criteria**

For purposes of this Attachment F, a covered encounter record is an encounter record that is covered under this Contract, not rejected by the rejection edits in the DEPARTMENT's Encounter Records Companion Guides and:

(1) the procedure codes are either covered by Medicaid as indicated on Medicaid's Reference File, or

(2) the Enrollee who received the service was a CHEC eligible, or

(3) the DEPARTMENT approves the payment for services described in Attachment B (Special Provisions), under Article VI (Authorization of Services and Notices of Action), A.2. (Process for the CONTRACTOR to Request Payment Authorization of Services); or

(4) the services provided are in lieu of services covered in the Utah Medicaid State Plan because they are cost-effective and of equal or higher quality.

c. Determination of Payments Subject to the Payment Limit

For purposes of determining whether the DEPARTMENT paid Molina more or less than the Payment Limit, the total amount the DEPARTMENT paid Molina is calculated as follows:

(1) the total amount as determined in Section A. (net of third party payments) excluding the 9% add-on fee that includes administration, case management services, profit earned, etc; plus

(2) other covered services not submitted as encounter records (such as Synagis) using the DEPARTMENT's Medicaid fee schedule.

d. Determination of Payment Limit

The DEPARTMENT will determine the Payment Limit by pricing, net of third party payments, and totaling all covered encounter records under B.3.b. plus other covered services not submitted as encounter records (such as Synagis) using the DEPARTMENT's Medicaid fee schedule.

For services that do not have a reimbursement amount in the DEPARTMENT's Reference File or the Reference File indicates that the service is manually priced, the amount the CONTRACTOR paid its provider will be the amount used in determining the Payment Limit.

The DEPARTMENT will provide documentary support for its calculation to Molina and afford Molina a reasonable opportunity to review and comment.

e. Reconciliation

The DEPARTMENT will then compare the difference between the amounts resulting from the calculations as provided in Section B.3.c. and Section B.3.d.

(1) If the amount the DEPARTMENT paid to Molina under Section B.3.c. is less than the amount the

DEPARTMENT would have paid on a fee-for-service basis under B.3.d., the DEPARTMENT will pay to Molina as an incentive payment either 75% of the resulting amount as savings sharing or 95% of the savings under the risk adjuster methodology, whichever is greater.

(2) If the amount the DEPARTMENT paid Molina under Section B.3.c. is more than the amount the DEPARTMENT would have paid on a fee-for-service basis under B.3.d., the DEPARTMENT will recoup the difference from Molina so that all payments to Molina equal the Payment Limit.

3. Examples of Savings Sharing Calculations

a. The risk-adjuster methodology shows aggregate savings of $3 million. Molina would be entitled to receive 95% of that amount ($2.85 million), but only up to 95% of the Payment Limit. Application of the Payment Limit methodology shows that on a fee-for-service basis, costs would have been only $2 million more than the amount the DEPARTMENT paid to Molina. Molina is entitled to the greater of 95% of the savings under the risk adjustor methodology ($2.85 million), but only up to 95% of the Payment Limit ($1.9 million), or 75% of the difference between the Payment Limit and the amount the DEPARTMENT paid Molina ($1.5 million). Therefore, Molina would be entitled to receive $1.9 million.

b. The risk-adjuster methodology shows aggregate savings of $3 million. Molina would be entitled to receive 95% of that amount ($2.85 million) but only up to 95% of the Payment Limit. Application of the Payment Limit methodology shows that on a fee-for-service basis, costs would have been $4 million more than the amount the DEPARTMENT paid to Molina. Molina is entitled to the greater of 95% of the savings under the risk adjuster methodology ($2.85 million), but only up to 95% of the Payment Limit ($3.8 million) or 75% of the difference between the Payment Limit and the amount the DEPARTMENT paid Molina ($3 million). Therefore Molina would be entitled to receive $3 million.

c. The risk-adjuster methodology shows no savings. Application of the Payment Limit methodology shows the amount the DEPARTMENT paid to Molina is $4 million less than the Payment Limit. The total amount the DEPARTMENT will pay Molina is 75% of $4 million or $3 million.

C. Payment Limit for the Contract Period from July 1, 2002 through June 30, 2004

Because it was not previously feasible to process encounter records through the MMCS edits for State fiscal years 2003 and 2004 to confirm compliance with the Payment Limit, the CONTRACTOR will submit encounters for these years. The encounter records will follow the Electronic Data Interchange (EDI) standards defined in the *Encounter Records 837 Institutional Companion Guide* and *Encounter Records 837 Professional Companion Guide*.

1. Validation of Compliance with Payment Limit

As soon as practicable, and using in all relevant respects the methodology described in Section B.3 above regarding the calculation of the Payment Limit and the comparison of the amounts paid to Molina with the Payment Limit, the DEPARTMENT will process Molina's encounter records for each fiscal year 2003 and fiscal year 2004. Each year will be processed and analyzed separately. Such claims processing is being done solely for the purpose of confirming compliance with the Payment Limit and no action will be taken by either party with respect to any previously paid or unpaid claim or particular group of claims.

2. Reconciliation

a. If the amount the DEPARTMENT paid to Molina for fiscal year 2003 or fiscal year 2004 is more than the amount of the Payment Limit for each year, the DEPARTMENT will recoup the difference from Molina. For purposes of such comparison for fiscal year 2004, the $1.5 million savings sharing payment made to Molina by the DEPARTMENT will be included in the calculation of the amounts paid to Molina for such year.

b. If the amount the DEPARTMENT paid to Molina for fiscal year 2003 or fiscal year 2004 is less than the amount of the Payment Limit for each year, the DEPARTMENT will pay Molina nothing. For purposes of such comparison for fiscal year 2004, the $1.5 million savings sharing payment made to Molina by the DEPARTMENT will be included in the calculation of the amounts paid to Molina for such year.

D. CHEC Screening Incentive Clause

1. CHEC Screening Goal

Molina will ensure that Medicaid children have access to appropriate well-child visits. Molina will follow the Utah EPSDT (CHEC) guidelines for the periodicity schedule for well-child protocol. The Centers for Medicare and Medicaid Services (CMS), mandates that all states have 80% of all children screened. The DEPARTMENT and Molina will work toward that goal.

2. Calculation of CHEC Incentive Payment

The DEPARTMENT will calculate Molina's annual participation rate based on information supplied by Molina under the CMS-416 EPSDT (CHEC) reporting requirements. Based

on the CMS-416 data, Molina's well-child participation rate was 64% for Federal Fiscal Year (FFY) 2004 (October 1, 2003 through September 30, 2004). The incentive payment for the Contract year ending June 30, 2005 will be based on Molina's FFY 2005 (October 1, 2004 through September 30, 2005) CMS-416 participation rate. The DEPARTMENT will pay Molina $10,000 if a rate of 80% or higher is attained during FFY 2005.

The participation rate will be calculated no later than April 15, 2006; Molina will be notified of the incentive payment, if applicable, no later than April 30, 2006.

3. MOLINA's Use of Incentive Payment

The CONTRACTOR agrees to use this incentive payment to rewardMolina's employees responsible for improving the EPSDT (CHEC) participation rate.

E. Immunization Incentive Clause

The CONTRACTOR will ensure that Enrollees have access to recommended immunizations. Molina will follow the Advisory Committee on Immunization Practices' recommendations for immunizations for children.

1. Immunizations for two-year-olds

The National Immunization Survey reported that in 2003 Utah had a statewide immunization level of 78.8% for two-year-olds. Molina's 2003 HEDIS rate was 62.1% for the Combination 1 immunization measure for two-year olds. Based on Molina's 2004 HEDIS result for the Combination 1 immunization measure, the DEPARTMENT will pay Molina $300 for each full percentage point above 62.1%.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the HEDIS immunization rate for two-year olds.

2. Immunizations for adolescents

The DEPARTMENT realizes it is important that adolescents are vaccinated according to the schedule recommended by the Advisory Committee on Immunization Practices and other professional groups. Molina's 2003 HEDIS rate was 22.5% for the Combination 1 immunization measure for adolescents. Based on Molina's 2004 HEDIS measure for adolescent immunizations, the DEPARTMENT will pay Molina $300 for each full percentage point above 22.5.8% up to 72.5%.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the HEDIS immunization rate for adolescents.

3. Immunizations for adults

The DEPARTMENT will provide an incentive to Molina using an influenza measure developed by the DEPARTMENT and the Office of Health Care Statistics. The measurement is the percentage of Enrollees age 50 and older who receive an influenza immunization during the previous year's flu season (September 1 of the previous year through May 31 of the measurement year). The baseline year is September 1, 2002 through August 31, 2003. Based on Molina's percentage for the flu season ending in 2005, the DEPARTMENT will pay Molina $300 for each full percentage point above Molina's percentage in the baseline year up to 50 percentage points above the baseline year.

The CONTRACTOR agrees to use this incentive payment to reward Molina's employees responsible for improving the influenza immunization rate for adults.

F. Quarterly Report of Costs Incurred for Administration, Case Management Services, Etc.

1. On a quarterly basis, the DEPARTMENT is required to report costs incurred for administration, case management services, etc., from non-risk managed care contracts with Federal Financial Participation (FFP). This reporting is required 30 days after the quarters ending March 31, June 30, September 30, and December 31. In order to meet this requirement, Molina must submit the cost data to the DEPARTMENT by the 25th of each month following each quarter's end.

2. The CONTRACTOR will report to the DEPARTMENT its costs incurred for administration, case management services, profit earned, etc. in an Excel spreadsheet. Molina will develop a cost reporting plan that documents methods used for reporting including direct assignment

and/or allocation process. The purpose of the plan methods is to facilitate any reviews that the DEPARTMENT conducts.

The CONTRACTOR will itemize its costs incurred into at least the following cost categories:

a. Family Planning
b. Claims Processing
c. Provider Enrollment
d. Prior Authorization
e. Case Management Services/Care Coordination
f. Disease Management Programs
g. Perinatal Care Programs
h. Educational Newsletters and other Outreach
i. Provider Credentialing and Re-credentialing
j. HEDIS Reporting
k. Encounter Data Submitted to the DEPARTMENT
l. Grievance and Appeals Processes
m. Work related to the DEPARTMENT's External Quality Review Organization
n. Quality Improvement Programs
o. Quality Committees
p. Performance Improvement Projects
q. Health Needs Assessments
r. Utilization Management other than prior authorization
s. Other General Administrative Costs (in detail)
t. Profit from Operations Before Taxes
u. Taxes from Operations

For each of the cost categories that have a personnel component, Molina will break out the costs by skilled Medical Professional; i.e, doctors, registered nurses, pharmacists, social workers, etc.

G. Other Payment-Related References

Attachment A, Article III, #4, #5, and #6 - (unauthorized changes to contract)
Attachment B, Article XI - Other Requirements (Fraud & Abuse)
Article XII - Payments (Third Party Liability)
Article XIII - Records and Reporting Requirements (Accuracy of Data)
Article XIV - Compliance/Monitoring (Right to Audit)
Article XV - Termination of Contract

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

2006 – 2007 CONTRACT

FOR

HEALTHY OPTIONS

AND

STATE CHILDREN'S HEALTH
INSURANCE PLAN

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

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1. **DEFINITIONS**

The following definitions shall apply to this Contract:

1.1 **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).

1.2 **Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of Washington, relating to the provision of health care when an individual is incapacitated (WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I).

1.3 **Ancillary Services** means health services ordered by a provider including, but not limited to, laboratory services, radiology services, and physical therapy.

1.4 **Appeal** means a request for review of an action (42 CFR 438.400(b)).

1.5 **Appeal Process** means the Contractor's procedures for reviewing an action.

1.6 **Children with Special Health Care Needs** means children identified by DSHS to the Contractor as children served under the provisions of Title V of the Social Security Act and children identified by the Contractor as having special health care needs.

1.7 **Cold Call Marketing** means any unsolicited personal contact by the Contractor or its designee, with a potential enrollee or an enrollee with another HO/SCHIP contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

1.8 **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

1.9 **Consumer Assessment of Health Plans Survey (**CAHPS®**)** means a commercial and Medicaid standardized survey instrument used to measure client experience of health care.

1.10 **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions in providers or service areas, between HO/SCHIP contractors and between Medicaid fee-for-service and HO/SCHIP in a manner that does not interrupt medically necessary care or jeopardize the enrollee's health.

1.11 **Coordination of Care** means the Contractor's mechanisms to assure that the enrollee and providers have access to and take into consideration, all required

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information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services (42 CFR 438.208).

1.12 **Covered Services** means medically necessary services, as set forth in Section 11, Benefits, covered under the terms of this Contract.

1.13 **Duplicate coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under Healthy Options/SCHIP.

1.14 **EPSDT** (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r) and the DSHS EPSDT program policy and billing instructions (See Exhibit A for website link). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance

abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. EPSDT services covered by the Contractor are described in Section 11, Benefits.

1.15 **Eligible Clients** means Medicaid recipients certified eligible by DSHS, living in the service area, and eligible to enroll for health care services under the terms of this Contract, as described in Section 2.2.

1.16 **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: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

1.17 **Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and are needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

1.18 **Enrollee** means an Medicaid recipient eligible for any medical program who is enrolled in Healthy Options/SCHIP managed care through a health care plan having a Contract with DSHS (42 CFR 438.10(a)).

1.19 **Enrollee with Special Health Care Needs** means a Medicaid recipient who has chronic and disabling conditions as defined in WAC 388-538-050.

1.20 **External Quality Review (EQR)** means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to Medicaid recipients (42 CFR 438.320).

1.21 **External Quality Review Organization (EQRO)** means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both (42 CFR 438.320). DSHS must contract with one EQRO to conduct either EQR alone or EQR-related activities and may contract with additional EQROs to conduct EQR-related activities as set forth in 42 CFR 438.358.

1.22 **External Quality Review Protocols** means a series of nine (9) procedures or guidelines for validating performance. Two of the nine protocols must be used by state Medicaid agencies. These are: 1) Determining Contractor compliance with federal Medicaid managed care regulations; and 2) Validation of performance improvement projects undertaken by the Contractor. The current Centers for Medicare and Medicaid Services (CMS) Protocols (See Exhibit A for website link).

1.23 **External Quality Review Report - (EQRR)** means a technical report that describes the manner in which the data from all EQR activities are aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor. DSHS will provide a copy of the EQRR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, enrollees and potential enrollees of the Contractor, recipient advocacy groups, and members of the general public. DSHS must make this information available in alternative formats for persons with sensory impairments, when requested.

1.24 **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

1.25 **Grievance Process** means the procedure for addressing enrollees' grievances.

1.26 **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the fair hearing system (42 CFR 438.400).

1.27 **Health Care Professional** means a physician or any of the following acting within their scope of practice; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, pharmacist and certified respiratory therapy technician (42 CFR 438.2).

1.28 **Health Employer Data and Information Set - (**HEDIS®**)** means a set of standardized performance measures designed to ensure that healthcare

purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS® are related to many significant public health issues such as immunizations, smoking, asthma, and diabetes. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

1.29 **Health Employer Data and Information Set (**HEDIS®**) Compliance Audit Program** means a set of standards and audit methods used by an NCQA certified auditor to evaluate information systems capabilities assessment (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HD standards).

1.30 **Managed Care** means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.

1.31 **Managed Care Organization (MCO)** means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with DSHS under a comprehensive risk contract to provide prepaid health care services to eligible DSHS clients under the department's managed care programs (WAC 388-538-050).

1.32 **Marketing** means any communication from the Contractor to a potential enrollee or enrollee with another DSHS contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either to not enroll in, or to disenroll from, another DSHS contracted MCO (CFR 438.104(a)).

1.33 **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing. (42 CFR 438.104(a)).

1.34 **Medically Necessary Services** means services that meet the definition in WAC 388-500-0005. In addition, medically necessary services shall include services related to the enrollee's ability to achieve age-appropriate growth and development.

1.35 **National CAHPS® Benchmarking Database - (NCBD)** means a national repository for data from the Consumer Assessment of Health Plans Survey (CAHPS). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.

1.36 **National Committee for Quality Assurance - (NCQA)** means an organization responsible for developing and managing health care measures that assess the quality of care and services that commercial and Medicaid managed care clients receive.

1.37 **Participating Provider** means a person, health care provider, practitioner, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this Contract.

1.38 **Peer-Reviewed Medical Literature** means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.39 **Physician Group** means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

1.40 **Physician Incentive Plan** means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this Contract.

1.41 **Post-stabilization 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 (42 CFR 438.114 and 42 CFR 422.113).

1.42 **Potential Enrollee** means any Medicaid recipient eligible for enrollment in Healthy Options/SCHIP who is not enrolled with a health care plan having a contract with DSHS (42 CFR 438.10(a)).

1.43 **Primary Care Provider (PCP)** means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of primary care provider is inclusive of the definition of primary care physician in 42 CFR 400.203 and all Federal requirements for primary care physicians will be applicable to primary care providers as the term is used in this Contract.

1.44 **Quality** as it pertains to external quality review means the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of

health services that are consistent with current professional knowledge (42 CFR 438.320).

1.45 **Risk** means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined herein.

1.46 **Service Areas** means the geographic areas covered by this Contract as described in Section 2.1.

1.47 **State Children's Health Insurance Program (SCHIP)** means a state-funded program to provide access to medical care for children whose family income exceeds the limit for Medicaid eligibility, but is not greater than two hundred fifty percent of the federal poverty level (FPL). SCHIP is authorized by Title XXI of the Social Security Act and by RCW 74.09.450 (WAC 388-542).

1.48 **Subcontract** means a written agreement between the Contractor and a subcontractor, or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this Contract.

1.49 **Validation** means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis (42 CFR 438.320).

2. ENROLLMENT

2.1 **Service Areas:**

2.1.1 The Contractor's service areas are described in Exhibit B, Premiums, Service Areas, and Capacity. DSHS shall update Exhibit B, Premiums, Service Areas, and Capacity for service area changes as describe herein.

2.1.2 Clients in the eligibility groups described in Section 2.2 are eligible to enroll with the Contractor if they reside in the Contractor's service areas.

2.1.3 Service Area Changes:

2.1.3.1 With the written approval of DSHS, the Contractor may expand into additional service areas at any time by giving written notice to DSHS, along with evidence, as DSHS may require, demonstrating the Contractor's ability to support the expansion. DSHS may withhold approval of a requested expansion, if, in DSHS' sole judgment, the requested expansion is not in the best interest of DSHS.

2.1.3.2 The Contractor may decrease service areas by giving DSHS ninety (90) calendar days written notice. The decrease shall not be effective until

the first day of the month that falls after the ninety (90) calendar days has elapsed.

2.1.3.3 The Contractor shall notify enrollees affected by any service area decrease sixty (60) calendar days prior to the effective date. Notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a service area decrease sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

2.1.4 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, DSHS shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.1.5 DSHS shall determine, in its sole judgment, which zip codes fall within each service area. No zip code will be split between service areas.

2.1.6 DSHS will determine whether an enrollee resides within a service area.

2.2 **Eligible Client Groups**: DSHS shall determine eligibility for enrollment under this Contract. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract, and must enroll in Healthy Options/SCHIP unless the enrollee has duplicate coverage as defined herein, has comparable coverage as defined herein, or is exempted pursuant to Section 2.4.

2.2.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for Medicaid.

2.2.2 Children, from birth through eighteen years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act ("H" Children).

2.2.3 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act ("S" women).

2.2.4 Children eligible for SCHIP (See Exhibit A for website link).

2.3 **Client Notification:** DSHS shall notify eligible clients of their rights and responsibilities as Healthy Options/SCHIP enrollees at the time of initial eligibility determination and at least annually. The Contractor shall provide enrollees with additional information as described in this Contract.

2.4 **Exemption from Enrollment:** A client may request exemption from enrollment. Each request for exemption will be reviewed by DSHS pursuant to WAC 388-

538 or WAC 388-542. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a disenrollment request consistent with the provisions of Section 2.9.

2.5 **Enrollment Period:** Subject to the provisions of Section 2.7, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one Healthy Options/SCHIP plan to another without cause, each month.

2.6 **Enrollment Process:** To enroll with the Contractor, the client, their representative or their responsible parent or guardian must complete and submit a DSHS enrollment form to DSHS, or call the DSHS, Division of Client Support toll-free enrollment number. If the client does not exercise their right to choose a Healthy Options/SCHIP plan, DSHS will assign the client, and all eligible family members, to a Healthy Options/SCHIP plan in accord with Section 5.12 of this Contract.

DSHS will make every effort to enroll all family members with the same Healthy Options/SCHIP plan. If a family member is covered by the Basic Health, DSHS will make every effort to enroll the remainder of the family with the same managed care plan if the plan contracts with DSHS to provide Healthy Options/SCHIP. If the plan does not contract with DSHS, the remaining family members will be enrolled with a single, but different Healthy Options/SCHIP plan of the client's choice, or the client will be assigned as described above if they do not choose.

2.7 **Effective Date of Enrollment:**

2.7.1 Except for newborns whose mother is enrolled in a Healthy Options/SCHIP plan, enrollment with the Contractor shall be effective on the later of the following dates:

2.7.1.1 If the enrollment is processed on or before the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.7.1.2 If the enrollment is processed after the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.7.2 Newborns whose mothers are enrollees shall be deemed enrollees and enrolled beginning from the newborn's date of birth or the mother's date of enrollment, whichever is later. If the mother is disenrolled before the newborn receives a separate client identifier from DSHS, the newborn's coverage shall end when the mother's coverage ends, except as provided in Section 11.12, Enrollee Hospitalized at Disenrollment. If the newborn does not receive a separate client identifier by the sixtieth (60th) day of life, supplemental premiums and coverage shall only be available through the end of the month in which the sixtieth (60th) day of life falls in accord with

Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS (See Exhibit A for website link).

2.7.3 Adopted children shall be covered consistent with the provisions of Title 48 RCW.

2.7.4 No retroactive coverage is provided under this Contract, except as described in this Section.

2.8 **Enrollment Listing and Requirements for Contractor's Response:**

2.8.1 Before the end of each month DSHS will provide the Contractor with an electronic file listing the Contractor's enrollees whose enrollment is terminated by the end of that month, and the Contractor's enrollees for the following month. The electronic file will be provided via a Health Insurance Portability and Accountability Act (HIPAA) compliant secure web-based transfer system in the 834 benefit enrollment and maintenance format.

2.8.2 The Contractor shall have ten (10) calendar days from the receipt of the enrollment listing to notify DSHS in writing of the refusal of an application for enrollment or any discrepancy regarding DSHS' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by DSHS. The effective date of enrollment specified by DSHS shall be considered accepted by the Contractor and shall be binding if the notice is not timely or DSHS does not agree with the reasons stated in the notice. Subject to DSHS approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.8.2.1 DSHS has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for.

2.8.2.2 The enrollee is not eligible for enrollment under the terms of this Contract.

2.9 **Termination of Enrollment**:

2.9.1 Voluntary Termination: Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to DSHS or by calling the Medical Assistance Customer Service Center (MACSC) toll-free enrollment number. Requests for termination of enrollment may be made to enroll with another Healthy Options plan, or to disenroll from Healthy Options as provided in WAC 388-538 or WAC 388-542. Except as provided in WAC 388-538 or WAC 388-542, enrollees whose enrollment is terminated will be prospectively disenrolled. DSHS shall notify the Contractor of enrollee terminations pursuant to Section 2.8. The Contractor may not request voluntary disenrollment on behalf of an enrollee.

2.9.2 Involuntary Termination Initiated by DSHS for Ineligibility: The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.9.2.1 When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.9.2.1.1 The first day of the month following the month in which the termination is processed by DSHS if the termination is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by DSHS of the termination

prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.1.2 Effective the first day of the second month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.2 Enrollees Eligible for Social Security Income (SSI):

2.9.2.2.1 Newborn enrollees with a date-of-birth after calendar year 2003 who are determined by the Social Security Administration (SSA) to have an SSI eligibility effective date within the first sixty-days of life, not counting the birth date, shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the State Data Exchange (SDX). Such newborn enrollees will be disenrolled retroactively effective the date-of-birth. DSHS shall recoup premiums paid in accord with Section 4.5.5.

2.9.2.2.2 Except as provided in Section 2.9.2.2.1, enrollees determined by the SSA to be eligible for SSI shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the electronic SDX. Such enrollees will be disenrolled prospectively as described in Section 2.9.2.1. DSHS shall not recoup any premiums for enrollees determined SSI eligible and the Contractor shall be responsible for providing services under the terms of this Contract until the effective date of disenrollment.

2.9.2.2.3 If the Contractor believes an enrollee has been determined by SSA to be eligible for SSI, the Contractor shall present documentation of such eligibility to DSHS, DSHS will attempt to verify the eligibility and, if the enrollee is SSI eligible, DSHS will act upon SSI eligibility in accord with this Section.

2.9.3 Involuntary Termination Initiated by DSHS for Comparable Coverage or Duplicate Coverage:

2.9.3.1 The Contractor shall notify DSHS as set forth below when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.9.3.1.1 Within fifteen (15) working days when an enrollee is verified as having duplicate coverage, as defined herein.

2.9.3.1.2 Within sixty (60) calendar days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

2.9.3.2 DSHS will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

2.9.3.2.1 When the enrollee has duplicate coverage that has been verified by DSHS, DSHS shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as describe in Section 4.5, Recoupments.

2.9.3.2.2 When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

2.9.4 Involuntary Termination Initiated by the Contractor: To request involuntary termination of an enrollee, the Contractor shall send written notice to DSHS as described in Section 12.26, Notices. Involuntary termination will occur only with written DSHS approval. DSHS shall review each request on a case by case basis, and approve or disapprove the request for termination within thirty (30) working days of receipt of such notice and the documentation required to substantiate the request. For the termination to be effective, DSHS must approve the termination request, notify the Contractor, and disenroll the enrollee. The Contractor shall continue to provide services to the enrollee until they are disenrolled. DSHS will not disenroll an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from his or her special needs or diminished mental capacity (WAC 388-538-130). DSHS shall

involuntarily terminate the enrollee when the Contractor has substantiated in writing all of the following:

2.9.4.1 The enrollee's behavior is inconsistent with the Contractor's rules and regulations, such as intentional misconduct;

2.9.4.2 The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and

2.9.4.3 The enrollee received written notice from the Contractor of its intent to request the enrollee's disenrollment, unless the requirement for notification has been waived by DSHS because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

2.9.5 An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive covered services, as described in Section 11.1, Scope of Services, at the Contractor's expense, through the end of that month.

In no event will an enrollee be entitled to receive services and benefits under this Contract after the last day of the month in which his or her enrollment is terminated, unless the enrollee is hospitalized at disenrollment; in accord with Section 11.12, Enrollee Hospitalized at Disenrollment.

2.10 **Enrollment Not Discriminatory**:

2.10.1 The Contractor will not discriminate against enrollees or potential enrollees on the basis of health status or need for health care services (42 CFR 438.6(d)(3)).

2.10.2 The Contractor will not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 CFR 438.6(d)(4)).

3. MARKETING AND INFORMATION REQUIREMENTS

3.1 **Marketing:** The Contractor, and any subcontractors, shall comply with the following requirements regarding marketing (42 CFR 438.104):

3.1.1 All marketing materials must be reviewed by and have the prior written approval of DSHS.

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

3.1.3 Marketing materials must be distributed in all service areas the Contractor serves.

3.1.4 Marketing materials must be in compliance with Section 3.3, Equal Access for Enrollees and Potential Enrollees with Communication Barriers.

3.1.4.1 Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials.

3.1.4.2 DSHS may determine, in its sole judgment, if materials that are primarily visual meet the requirements of this Contract.

3.1.5 The Contractor shall not offer anything of value as an inducement to enrollment.

3.1.6 The Contractor shall not offer the sale of other insurance to attempt to influence enrollment.

3.1.7 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

3.2 **Information Requirements for Enrollees and Potential Enrollees:**

3.2.1 The Contractor shall provide sufficient, accurate oral and written information to potential enrollees to assist them in making an informed decision about enrollment (SSA 1932(d)(2) and 42 CFR 438.10).

3.2.2 The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care.

3.2.3 All enrollee information shall have the prior written approval of DSHS.

3.2.4 Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of DSHS, the change is significant in regard to the enrollees' quality of or access to care. DSHS shall notify the Contractor of any significant change in writing.

3.2.5 The Contractor's written information to enrollees and potential enrollees shall include:

3.2.5.1 How to choose a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.5.2 How to change a PCP.

3.2.5.3 How to access services outside the Contractor's service area.

3.2.5.4 How to access Emergency Services.

3.2.5.5 General information about accessing hospital care and how to get a list of hospitals that are available to enrollees.

3.2.5.6 General information regarding specialists available to enrollees and how to obtain specific information including a list of specialists that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.5.7 How to obtain information regarding any limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP.

3.2.5.8 How to obtain information regarding Physician Incentive Plans (42 CFR 422.208 and 422.210), and information on the Contractor's structure and operations.

3.2.5.9 Informed consent guidelines.

3.2.5.10 Information regarding conversion rights under RCW 48.46.450 or RCW 48.44.370.

3.2.5.11 How to request a disenrollment.

3.2.5.12 The following information regarding advance directives:

3.2.5.12.1 A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.

3.2.5.12.2 The written policies and procedures of the Contractor concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive.

3.2.5.12.3 An enrollee's rights under state law.

3.2.5.13 How to recommend changes in the Contractor's policies and procedures.

3.2.5.14 Health promotion, health education and preventive health services available.

3.2.5.15 Information on the Contractor's Grievance System including:

3.2.5.15.1 How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential except as needed to process the grievance, appeal or independent review.

3.2.5.15.2 How to initiate a grievance or file an appeal, in accord with the Contractor's DSHS approved policies and procedures regarding grievances and appeals.

3.2.5.15.3 How to request a fair hearing after the Contractor's appeal process is exhausted, how to request a fair hearing and the rules that govern representation at the fair hearing.

3.2.5.15.4 How to request an independent review in accord with RCW 48.43.535 and WAC 246-305 after the fair hearing process is exhausted and how to request an independent review.

3.2.5.15.5 The enrollees' right to appeal an independent review decision to the Board of Appeals and how to request such an appeal.

3.2.5.15.6 The requirements and timelines for grievances, appeals, fair hearings, independent review and Board of Appeals.

3.2.5.15.7 The enrollees' rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or fair hearing.

3.2.5.15.8 The availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.

3.2.5.16 The enrollee's rights and responsibilities with respect to receiving covered services.

3.2.5.17 Information about covered benefits and how to contact DSHS regarding services that may be covered by DSHS, but are not covered benefits under this Contract.

3.2.5.18 Specific information about EPSDT.

3.2.5.19 Information regarding the availability of and how to access or obtain interpretation services and translation of written information at no cost to the enrollee.

3.2.5.20 How to obtain information in alternative formats.

3.2.5.21 The enrollee's right to and procedure for obtaining a second opinion.

3.2.5.22 The prohibition on charging enrollees for covered services and circumstances under which an enrollee might be charge for services.

3.3 **Equal Access for Enrollees and Potential Enrollees with Communication Barriers**: The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 CFR 438.10).

3.3.1 Oral Information:

3.3.1.1 The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English for all interactions between the enrollee or potential enrollee and the Contractor or any of its providers including, but not limited to, customer services, all appointments with any provider for any covered service, emergency services, and all steps necessary to file grievances and appeals.

3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters including, but not limited to handling enrollee grievances and appeals.

3.3.1.3 DSHS is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and fair hearings.

3.3.1.4 Hospitals are responsible for payment for interpreter services during inpatient stays.

3.3.1.5 Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

3.3.1.6 Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired at no cost to the enrollee or potential enrollee.(42 CFR 438.10(c)(4)).

3.3.2 Written Information:

3.3.2.1 The Contractor shall provide all generally available and client specific written materials in a form which may be understood by each individual enrollee and potential enrollee.

3.3.2.2 If 5% or more of the Contractor's enrollees speak a specific language other than English, generally available materials will be translated into that language.

3.3.2.3 For enrollees whose primary language is not translated as required by Section 3.3.2.2, the Contractor may meet the requirement of this Section by doing any one of the following:

3.3.2.3.1 Translating the material into the enrollee's or potential enrollee's primary reading language.

3.3.2.3.2 Providing the material on tape in the enrollee's or potential enrollee's primary language.

3.3.2.3.3 Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

3.3.2.3.4 Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee's acceptance of the material in an alternative medium or format (42 CFR 438.10(d)(1)(ii)).

3.3.2.3.5 Providing the material in English, if the Contractor documents the enrollee's or potential enrollee's preference for receiving material in English.

3.3.2.4 The Contractor shall ensure that all written information provided to enrollees or potential enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level and fulfils other requirements of the Contract as may be applicable to the materials (42 CFR 438.10(b)(1) and SMD letter 02/20/98). This shall not be interpreted to include Disease Management materials, preventative services or other education materials used by the Contractor for health promotion efforts. DSHS may make exceptions to the sixth grade reading level when, in the sole judgment of DSHS, the nature of the materials do not allow for a sixth grade reading level or the enrollees' needs are better served by allowing a higher reading level. DSHS approval of exceptions to the sixth grade reading level must be in writing.

3.3.2.5 All written materials must have the written approval of DSHS prior to use. For client specific written materials, the Contractor may use templates that have been pre-approved in writing by DSHS. The

Contractor must provide DSHS with a copy of all approved materials in final form.

4. **PAYMENT**

4.1 **Rates/Premiums:**

4.1.1 Subject to the provisions of Section 12.32, Sanctions, DSHS shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this Contract. DSHS shall pay the Contractor, on or before the tenth (10th) working day of the month based on the DSHS list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.726(b) and 42 CFR 438.730(e).

4.1.2 The Contractor shall reconcile the electronic benefit enrollment listing with the premium payment information and submit a claim to DSHS for any amount due the Contractor within three hundred sixty five (365) calendar days of the month of service. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

4.1.3 The statewide Base Rate, Geographical Adjustment Factors, Risk Adjustment Factors and Age/Sex Factors are in Exhibit B, Premiums, Service Areas, and Capacity.

4.1.4 The monthly premium payment will be calculated as follows:

Premium Payment = Base Rate x Age/Sex Factor x Risk Adjustment Factor x Geographical Adjustment Factor (X Quality Adjustment Factor as described herein).

4.1.5 Within sixty (60) calendar days following the end of the annual legislative session, DSHS will publish the Base Rate for the following calendar year. If the Contractor will not continue to provide HO/SCHIP services in the following calendar year, the Contractor shall so notify DSHS no later than September 2, of the current year under the provisions of Section 12.26 Notices. If the Contractor so notifies DSHS, this Contract shall terminate, without penalty to either party, effective midnight, December 31, of the current year. The termination will be considered a termination for convenience under the provisions of Section 12.37, Termination for Convenience, but neither party shall have the right to assert a claim for costs.

4.1.6 The Geographical Adjustment Factors will be adjusted by DSHS for the period January 1, through December 31, of the following year for changes in utilization and to provide for the payment of Critical Access Hospitals

(CAH) as required in Section 3.13., Payments to CAH. Geographical Adjustment Factors may be prospectively updated by DSHS if, in DSHS' judgment, there are material changes in rates or utilization related to CAH.

4.1.7 The Risk Adjustment Factor will be recalculated for premiums paid beginning in May for each year based on enrollment with the Contractor on March 1st of that year, using the most currently available 12 months of reported encounter data. Risk Adjustment Factors may also be recalculated by DSHS if, in DSHS' sole judgment, changes in contractor participation in HO/SCHIP require rebalancing of the Risk Adjustment Factors.

4.1.8 Each year DSHS will develop a Quality Incentive based on HEDIS® measures for childhood immunizations and well child visits. If the Contractor will receive a Quality Incentive, the amount will be stated in Exhibit B, Premiums, Service Areas, and Capacity and will be paid in the first quarter of the year.

4.1.9 DSHS will update Exhibit B, Premiums, Service Areas, and Capacity to add the Base Rate and any changes in service areas, capacity, Geographical Adjustment Factors, and Risk Adjustment Factors as needed without amending this Contract. DSHS will provide such updates to the Contractor in writing.

4.1.10 DSHS shall automatically generate newborn premiums whenever possible. For newborns whose premiums DSHS is not able to automatically generate the Contractor shall submit a supplemental premium payment request to DSHS within 365 calendar days of the month of service. The Contractor shall be responsible for reviewing monthly listings provided by DSHS of the newborn premiums DSHS cannot generate automatically, as well as premium payment notices, to determine whether a supplemental premium request needs to be submitted. DSHS shall pay supplemental premiums through the end of the month in which the sixtieth (60th) day of life occurs.

4.1.11 DSHS shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

4.1.12 The Contractor shall be responsible for covered medical services provided to the enrollee in any month for which DSHS paid the Contractor for the enrollee's care under the terms of this Contract.

4.2 **Delivery Case Rate Payment:** A one-time payment of $4,320.50 shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if it has incurred expenses for and paid for labor and delivery. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and

delivery to terminate the pregnancy. The Contractor shall submit a supplemental premium request for payment to DSHS after the enrollee delivers.

4.3 **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the Contract period only if DSHS, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control,

which would justify such a renegotiation.

4.4 **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to DSHS for the services rendered.

4.5 **Recoupments:** Unless mutually agreed to by the parties, DSHS shall only recoup premium payments for individual enrollees who are:

4.5.1 Covered by the Contractor with duplicate coverage.

4.5.2 Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

4.5.3 Retroactively disenrolled as a result of the enrollee's placement in foster care.

4.5.4 Retroactively disenrolled consistent with the provisions of Section 2.9.1.

4.5.5 Newborns determined to have an SSI eligibility effective date within the first sixty (60) days of life in accord with Section 2.9.2.2.1. DSHS shall recoup all premiums paid for the enrollee, but not the birth mother, back to the month of birth.

4.5.6 Found ineligible for enrollment with the Contractor and DSHS so notifies the Contractor before the first day of the month for which the premium is paid.

4.5.7 The Contractor may recoup payments made to providers for services provided to enrollees during the period for which DSHS recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to DSHS through its FFS program.

4.5.8 When DSHS retroactively disenrolls an individual, DSHS will not disenroll any other family member, except for newborns whose mother is disenrolled for duplicate coverage.

4.6. **Rate Setting Methodology:** DSHS sets actuarially sound Managed care rates that:

4.6.1. Have been developed in accord with generally accepted actuarial principles and practices;

4.6.2. Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

4.6.3. Have been certified, as meeting the requirements of 42 CFR 438.6(c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

4.7. **Copayments:** The Contractor may impose copayments for services to enrollees for the same services, populations and amounts that DSHS implements in its fee-for-service program.

4.8. **Information for Rate Setting:** For rate setting only, the Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. The experience information shall be provided directly to an actuary designated by DSHS. The designated actuary will determine the timing, content, format and medium for such information.

4.9. **Payments to Critical Access Hospitals (CAH):** For services provided by CAH to enrollees, the Contractor shall pay the CAH the prospective Inpatient and Outpatient Departmental Weighted Cost-to-Charge rates published by DSHS.

4.10. **Encounter Data:** The Contractor shall comply with the required format provided in the Encounter Data Transaction Guide published by DSHS (See Exhibit A for website link). Encounter data includes claims paid by the Contractor for services delivered to enrollees through the Contractor during a specified reporting period. DSHS collects and uses this data for many reasons such as: federal reporting; rate setting and risk adjustment; service verification, managed care quality improvement program, utilization patterns and access to care; DSHS hospital rate setting; and research studies.

DSHS may change the Encounter Data Transaction Guide with one hundred and fifty (150) calendar days written notice to the Contractor. The Encounter Data Transaction Guide may be changed with less than one hundred and fifty (150) calendar days notice by mutual agreement of the Contractor and DSHS. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

5. ACCESS AND CAPACITY

5.1. **Network Capacity:**

5.1.1. The Contractor agrees to maintain and monitor the support services and a provider network sufficient to serve the enrollee capacity stated in Exhibit B, Premiums, Service Areas, and Capacity, consistent with the requirements of this Contract.

5.1.2. The Contractor agrees to provide medical services required by this Contract through non-participating providers, at a cost to the enrollee that is no greater than if the services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 CFR 438.206(b)(1)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.

5.1.3. The Contractor must submit documentation regarding its maintenance and monitoring of the network and adequate capacity and services, as specified by DSHS, at any time upon DSHS request or when there has been a change in the Contractor's network or operations that, in the sole judgment of DSHS, would adversely affect adequate capacity and/or the Contractor's ability to provide services.

5.1.4. With the written approval of DSHS, the Contractor may increase capacity or set its capacity to unlimited at any time by giving written notice to DSHS. The Contractor shall provide evidence, as DSHS may require, demonstrating the Contractor's ability to support the capacity increase. DSHS may withhold approval of a requested capacity increase, if, in DSHS' sole judgment, the requested increase is not in the best interest of DSHS. The Contractor may decrease capacity by giving DSHS ninety (90) calendar days written notice. The decrease shall not be effective until the first day of the month which falls after the ninety (90) calendar days has elapsed. Exhibit B, Premiums, Service Areas, and Capacity will be updated by DSHS for increases and decreases in capacity.

5.2. **Service Delivery Network:** In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 438.206(b)):

5.2.1. The stated capacity in Exhibit B of this Contract

5.2.2. Adequate access to all services covered under this Contract

5.2.3. The expected utilization of services, taking into consideration the characteristics and health care needs of the Medicaid population represented by the Contractor's enrollees;

5.2.4. The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;

5.2.5. The number of network providers who are not accepting new Medicaid enrollees;

5.2.6. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by potential enrollees, and whether the location provides physical access for the Contractor's enrollees with disabilities.

5.2.7. The cultural, ethnic, race and language needs of enrollees.

5.3. **Timely Access to Care**: The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services. The Contractor shall ensure that:

5.3.1. Network providers offer access comparable to that offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Contractor serves only Medicaid enrollees. (42 CFR 438.206(b)(1) & (c)(1));

5.3.2. Mechanisms are established to ensure compliance by providers;

5.3.3. Providers are monitored regularly to determine compliance; and

5.3.4. Corrective action is initiated and documented if there is a failure to comply.

5.4. **Hours of Operation for Network Providers:** The Contractor must require that network providers offer hours of operation for enrollees that are no less than the hours of operation offered to any other patient (42 CFR 438.206(c)(1)).

5.5. **24/7 Availability:** The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services may be provided directly by the Contractor or may be delegated to subcontractors (42 CFR 438.206(c)(1)(iii)).

5.5.1. Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of medical condition.

5.5.2. Authorization of services.

5.6. **Appointment Standards:** The Contractor shall comply with appointment standards that are no longer than the following (42 CFR 438.206(c)(1)(i)):

5.6.1. Non-symptomatic (i.e. preventive care) office visits shall be available from the enrollee's PCP or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

5.6.2. Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within ten (10) calendar days.

A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

5.6.3. Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

5.6.4. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

5.7. **Integrated Provider Network Database (IPND):** The Contractor shall report their complete provider network, to include all current contracted providers, monthly to DSHS through the designated data management contact in accord with the Provider Network Reporting Requirements published by DSHS (See Exhibit A for website link).

5.8. **Provider Network - Distance Standards:**

5.8.1. The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit B, Premiums, Service Areas, and Capacity.

5.8.1.1. PCP

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

5.8.1.2. Obstetrics

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

5.8.1.3. Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

Urban: 2 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

5.8.1.4. Hospital

Urban/Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

5.8.1.5. Pharmacy

Urban: 1 within 10 miles for 90% of Healthy Options enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of Healthy Options enrollees in the Contractor's service area.

5.8.2. DSHS may, at its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require to support the request. If the closest qualified provider is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest qualified provider may be a provider not participating with the Contractor.

5.9. **Standards for Specialty and Primary Care Providers:** The Contractor defines providers that serve as PCPs and high volume specialty care providers (SCPs) and establishes measurable standards for the number of both PCPs and SCPs. The Contractor shall analyze performance against standards at minimum, annually.

5.10. **Access to Specialty Care:**

5.10.1. The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a specialist who is not available within the Contractor's provider network, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network.

5.10.2. The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

5.11. **Capacity Limits and Order of Acceptance:** The Contractor shall provide care to enrollees up to the capacity limits in Exhibit B, Premiums, Service Areas, and Capacity. The Contractor shall accept enrollees up to the total capacity limit in each service area, and enrollees will be accepted in the order in which they apply. DSHS shall enroll all eligible clients with the contractor of their choice if the Contractor has not reached the capacity limit unless DSHS determines, in its sole judgment, that it is in DSHS' best interest to withhold or limit enrollment with the Contractor. The Contractor shall accept clients who are assigned by DSHS in accord with this Contract, WAC 388-538, and WAC 388-542, except as specifically provided in Section 2.8.

No eligible client shall be refused enrollment or re-enrollment, have their enrollment terminated, or be discriminated against in any way because of their health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 CFR 438.6(d)(1&3)).

5.12. **Assignment of Enrollees:**

5.12.1. Enrollees who do not select a plan in a service area shall be assigned to a plan in the following manner:

5.12.1.1. DSHS shall determine the total capacity of all contractors receiving assignments in each service area.

5.12.1.2. The Contractor's capacity in each service area, as stated in Exhibit B, Premiums, Service Areas, and Capacity, modified by increases and decreases in capacity made in accord with this Contract, shall be divided by the total capacity of all contractors receiving assignment in each service area. In any area where the Contractor's capacity is unlimited, DSHS will set the Contractor's capacity, for this calculation, at the total number of HO/SCHIP eligibles in the service area.

5.12.1.3. The result of the calculation in Section 4.10.1.2. will be multiplied by the total of the households to be assigned.

5.12.1.4. DSHS shall assign the number of households determined in Section 4.10.1.3. to the Contractor.

5.12.2. At DSHS' sole discretion, DSHS may not make assignments of enrollees to the Contractor in a service area if the Contractor's enrollment, when DSHS calculates assignments, is ninety percent (90%) or more of its capacity in that service area.

5.12.3. The Contractor may choose not to receive assignments or limit assignments in any service area by so notifying DSHS in writing at least sixty (60) calendar days before the first of the month it is requesting not to receive assignment of enrollees.

5.12.4. DSHS reserves the right to make no assignments, or to withhold or limit assignments to the Contractor, when, in its sole judgment, it is in the best interest of DSHS.

5.12.5. If either the Contractor or DSHS limits assignments as described herein, the Contractor's capacity, only for the purposes of the calculation in Section 4.10.1.2., shall be that limit.

5.13. **Provider Network Changes:**

5.13.1. The Contractor shall give DSHS a minimum of ninety (90) calendar days prior written notice, in accord with Section 12.26, Notices, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and/or the number of enrollees the Contractor has agreed to serve in a service area.

5.13.2. The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 CFR 438.10(f)(5)). Enrollee notices shall have prior approval of DSHS. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

6. **QUALITY OF CARE**

6.1. **Quality Assessment and Performance Improvement (QAPI) Program**

6.1.1. The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees that meets the provisions of 42 CFR 438, Subpart D, Medicaid Managed Care Protocols (See Exhibit A for website link).

6.1.1.1. The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.

6.1.1.2. The QAPI program structure shall include the following elements:

6.1.1.2.1. A written description of the QAPI program including identification of designated physician and behavioral health practitioners. The QAPI program description shall include:

6.1.1.2.1.1. A listing of all quality-related committee(s),

6.1.1.2.1.2. Descriptions of committee responsibilities,

6.1.1.2.1.3. Contractor staff and practicing provider committee participant titles,

6.1.1.2.1.4. Meeting frequency, and

6.1.1.2.1.5. Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.

6.1.1.2.2. A Quality Improvement Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee:

6.1.1.2.2.1. Recommends policy decisions,

6.1.1.2.2.2. Analyzes and evaluates the results of QI activities,

6.1.1.2.2.3. Institutes actions, and

6.1.1.2.2.4. Ensures appropriate follow-up.

6.1.1.2.3. An annual work plan.

6.1.1.2.4. An annual evaluation of the QAPI program to include an evaluation of performance improvement projects, trending of performance measures and evaluation of the overall effectiveness of the QI program.

6.1.2. The Contractor shall make available the QAPI program description, and information on the Contractor's progress towards meeting its goals to providers and enrollees upon request.

6.1.3. The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

6.1.3.1. A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity;

6.1.3.2. Evaluation of the delegated organization prior to delegation;

6.1.3.3. An annual evaluation of the delegated entity;

6.1.3.4. Evaluation of regular delegated entity reports; and

6.1.3.5. Follow-up on issues out of compliance with delegated agreement or DSHS contract specifications.

6.2. **Performance Improvement Projects**:

6.2.1. The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct at least five (5) Performance Improvement Projects (PIPs) of which at least three (3) are clinical and at least two (2) are non-clinical as described in 42 CFR 438.240 and as specified in the CMS protocol (See Exhibit A for website link).

6.2.2. The projects must be 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. Annually, through implementation of performance improvement projects the Contractor shall:

6.2.2.1. Measure performance using objective, quality indicators.

6.2.2.2. Implement system interventions to achieve improvement in quality.

6.2.2.3. Evaluate the effectiveness of the interventions.

6.2.2.4. Plan and initiate activities for increasing or sustaining improvement.

6.2.2.5. Report the status and results of each project to DSHS.

6.2.2.6. Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year (CFR 42 438.240).

6.2.3. Annually, the Contractor shall submit to DSHS three (3) clinical and two (2) non-clinical performance improvement projects which, in the judgment of the Contractor, best meet the requirements of a performance improvement project. Each project will be documented on a performance improvement project worksheet found in the Conducting Performance Improvement Projects (See Exhibit A for website link).

6.2.4. If any of the Contractor's Health Plan Employer Data and Information Set (HEDIS®) rates on Well Child Visits in the first 15 months (six (6) or more well child visits measure), Well Child Visits in the 3rd, 4th, 5th and 6th years of life, or Adolescent Well Care Visits

are below 60% in 2006 or 2007, the Contractor shall implement a clinical PIP designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 5.2.1.

6.2.5. If any of the Contractor's HEDIS® Combination 2, Childhood Immunization rates are below 70% in 2006 or below 75% in 2007, the Contractor shall implement a performance improvement project designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 5.2.1.

6.2.6. The Contractor shall continue the CAHPS® non-clinical performance improvement project(s) required in the 2004-2005 Healthy Options/SCHIP contract and communicated by DSHS to the Contractor in February 2005 unless directed otherwise in writing by DSHS.

6.2.7. In addition to the PIPs required under Sections 6.2.1 through 6.2.6. and upon request of DSHS, the Contractor shall participate in a yearly statewide performance measure reporting project, performance improvement project or research project designed by DSHS. The study shall be designed to maximize resources and reduce cost to contractors. The Contractor will receive copies of aggregate data and reports produced from these projects.

6.3. **Performance Measures using Health Employer Data and Information Set (HEDIS®):**

6.3.1. In accord with Section 12.26, Notices, the Contractor shall report to DSHS HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by DSHS. For the 2006 and 2007 HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDIS® Technical Specifications, unless directed otherwise by DSHS.

6.3.2. No later than June 15th of each year, HEDIS® measures shall be submitted electronically to DSHS using the NCQA data submission tool (DST) or other NCQA-approved method.

6.3.3. The following HEDIS® measures shall be submitted to DSHS in 2006:

6.3.3.1. Childhood Immunization

6.3.3.2. Chlamydia Screening in Women

6.3.3.3. Prenatal and Postpartum Care

6.3.3.4. Well Child Visits in the First 15 Months of Life

6.3.3.5. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.3.3.6. Adolescent Well Child Visits

6.3.3.7. Use of Appropriate Medications for People with Asthma

6.3.3.8. Children and Adolescents' Access to Primary Care Practitioners

6.3.3.9. Practitioner Turnover (for Primary Care Practitioners and OB/GYN and other Prenatal Care Practitioners only)

6.3.3.10. Inpatient Utilization-General Hospital/Acute Care

6.3.3.11. Ambulatory Care

6.3.3.12. Birth and Average Length of Stay, Newborns

6.3.4. The following HEDIS® measures shall be submitted to DSHS in 2007:

6.3.4.1. Childhood Immunization

6.3.4.2. Chlamydia Screening in Women

6.3.4.3. Prenatal and Postpartum Care

6.3.4.4. Well Child Visits in the First 15 Months of Life

6.3.4.5. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.3.4.6. Adolescent Well Child Visits

6.3.4.7. Use of Appropriate Medications for People with Asthma

6.3.4.8. Comprehensive Diabetes Care

6.3.4.9. Children and Adolescents' Access to Primary Care Practitioners

6.3.4.10. Practitioner Turnover (for Primary Care Practitioners and OB/GYN and other Prenatal Care Practitioners only)

6.3.4.11. Inpatient Utilization-General Hospital/Acute Care

6.3.4.12. Ambulatory Care

6.3.4.13. Birth and Average Length of Stay, Newborns

6.3.5. The Contractor shall submit raw HEDIS® data for three measures: Childhood Immunization, Use of Appropriate Medication for People with Asthma, and Children and Adolescents' Access to Primary Care Practitioners, no later than June 30th of each year. The Contractor shall submit the raw HEDIS® data to DSHS electronically, according to specifications communicated by DSHS to the Contractor no later than February of each year.

6.3.6. All measures shall be audited, by a National CAHPS® Benchmarking Database (NCBD) licensed organization in accord with methods described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures. DSHS will fund and the DSHS designated EQRO will conduct the audit.

6.3.7. The Contractor shall cooperate with DSHS' designated EQRO to validate the Contractor's Health Employer Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

6.3.7.1. If the Contractor does not have NCQA accreditation for Healthy Options managed care from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

6.3.7.2. If the Contractor has NCQA accreditation for Healthy Options managed care or is seeking accreditation with a scheduled NCQA visit in 2006 or 2007, the Contractor shall receive a full audit.

6.3.7.3. Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the Centers for Medicare and Medicaid (CMS) Validating Performance Measures protocol identified by the DSHS designated EQRO.

6.3.8. The Contractor shall provide evidence of trending of measures to assess performance in quality and safety of clinical care and quality of non-clinical or service-related care.

6.3.9. The Contractor shall collect and maintain data on ethnicity, race and language markers as established by DSHS on all enrollees by January 1, 2007. The Contractor shall record and maintain enrollee self-identified data as established by the Contractor.

6.3.10. The Contractor shall rotate HEDIS® measures only with the advance written permission of DSHS. The Contractor may request permission to rotate measures by making a written request to the DSHS contact named in the Notices section of this agreement. Childhood Immunization and well-child measures shall not be rotated.

6.4. **Consumer Assessment of Health Plans Survey (CAHPS®):**

6.4.1. In 2006, A DSHS designated EQRO shall conduct the CAHPS® Children and Children with Chronic Conditions survey based upon 2006 HEDIS® Specifications for Survey Measures.

6.4.1.1. The Contractor shall create the sampling frame file.

6.4.1.1.1. The Contractor shall receive file specifications and instructions specifying the format and other required information for the sample files from DSHS, or the DSHS designated EQRO, by November 30, 2005.

6.4.1.1.2. The Contractor shall submit the eligible sample frames to the DSHS designated EQRO by January 5, 2006.

6.4.1.1.3. The Contractor's eligible sample frame file(s) will be certified by the DSHS EQRO, a Certified HEDIS® Auditor.

6.4.1.1.4. The Contractor shall receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 30, 2006.

6.4.1.2. The Contractor will be allowed up to eight Contractor–determined supplemental questions and DSHS will also be allowed up to eight supplemental questions. The Contractor will be notified of DSHS selected eight supplemental questions.

6.4.1.2.1. The Contractor shall submit the questions to DSHS for written approval for the amount, content, and survey placement prior to December 15, 2005.

6.4.1.2.2. The Contractor shall receive a copy of the approved DSHS questionnaire for informational purposes by January 30, 2006. DSHS EQRO shall determine the questionnaire format, questions

and question placement, using the most recent HEDIS® version of the Children and Children with Chronic Conditions questionnaire, plus approved supplemental and/or custom questions as determined by DSHS.

6.4.1.3. The Contractor shall provide National CAHPS® Benchmarking Database (NCBD) submission information as determined by DSHS.

6.4.1.3.1. The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2006. The DSHS designated EQRO shall submit the data to the NCBD.

6.4.2. In 2007, the Contractor shall conduct the CAHPS® of adult Medicaid members enrolled in Healthy Options.

6.4.2.1. The Contractor shall contract with an NCQA certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the DSHS designated EQRO:

6.4.2.1.1. Contractor CAHPS® survey staff member contact, CAHPS® vendor name and CAHPS® primary vendor contact by January 5, 2007.

6.4.2.1.2. Timeline for implementation of vendor tasks by February 15, 2007.

6.4.2.2. The Contractor shall ensure the survey sample frame consists of all non-Medicare and non-commercial adult plan members (not just subscribers) 18 (eighteen) years and older with Washington State addresses. The Contractor shall submit the survey sample frame to DSHS by January 5, 2007. In administering the CAHPS® the Contractor shall:

6.4.2.2.1. Be allowed up to eight Contractor-determined supplemental questions.

6.4.2.2.2. Allow DSHS up to eight supplemental questions.

6.4.2.2.3. Be notified of DSHS' selected eight supplemental questions on or before November 1, 2005.

6.4.2.2.4. Submit their questions to DSHS for written approval prior to December 15, 2006.

6.4.2.2.5. Submit the eligible sample frame file(s) for certification by the DSHS designated EQRO, a Certified HEDIS® Auditor by January 5, 2007.

6.4.2.2.6. Receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 31, 2007.

6.4.2.2.7. Receive the approved DSHS questionnaire by January 31, 2007. DSHS EQRO shall determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid adult questionnaire (currently 3.0H), plus approved supplemental and/or custom questions as determined by DSHS.

6.4.2.2.8. Conduct the mixed methodology (mail and phone surveys) for CAHPS® survey administration.

6.4.2.2.9. Submit the final disposition report by June 1, 2007.

6.4.2.2.10. Submit a copy of the Washington State adult Medicaid response data set according to 2007 NCQA/CAHPS® standards to the DSHS designated EQRO by June 1, 2007.

6.4.2.3. The Contractor shall provide NCBD data submission information as determined by DSHS.

6.4.2.3.1. The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2007.

6.4.2.3.2. The DSHS designated EQRO shall submit the data to the NCBD.

6.4.2.4. The Contractor is required to include performance guarantee language in their vendor subcontracts that require a vendor to achieve at least a 35% response rate.

6.4.3. If a Contractor cannot conduct the required annual CAHPS® surveys (Children, Children with Chronic Conditions, or Adult) because of limited total enrollment and/or sample size, the Contractor shall notify DSHS in writing whether they have a physician or physician group at substantial financial risk in accord with the physician incentive plan requirements under Section 8.8.

6.5. **External Quality Review:**

6.5.1. The Contractor's quality program shall be examined using a series of required validation procedures. At DSHS' sole option, the examination shall be implemented and conducted by DSHS, its agent, or an EQRO. The following required activities will be validated:

6.5.1.1. Performance improvement projects;

6.5.1.2. Performance measures, and

6.5.1.3. A monitoring review of standards established by DSHS and included in this Contract to comply with 42 CFR 438.204 (g) and a comprehensive review conducted within the previous 3-year period (42 CFR 438.358(b)(1)(2)(3)).

6.5.2. The following optional activity will be validated annually:

6.5.2.1. Administration and/or validation of consumer or provider surveys of quality of care, i.e., the CAHPS® survey.

6.5.3. DSHS reserves the right to include additional optional activities described in 42 CFR 438.358 if additional funding becomes available and as mutually negotiated between DSHS and the Contractor. These additional, optional validation activities may include:

6.5.3.1. Validation of encounter data;

6.5.3.2. Calculation of performance measures in addition to those reported by the Contractor and validated by DSHS' EQRO;

6.5.3.3. Conduct of performance improvement projects in addition to those conducted by the Contractor and validated by DSHS or its designated EQRO; and

6.5.3.4. Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time.

6.5.4. The Contractor shall submit to an annual DSHS TeaMonitor and/or EQRO monitoring review. The monitoring review process uses standard methods and data collection tools and methods found in the CMS External Quality Review Protocols and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs.

6.5.4.1. The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by DSHS or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to enrollees.

6.5.4.2. The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report (EQRR). The EQRR is a detailed technical report that describes the manner in which the data from all activities described in Sections 6.4.1 through 6.4.3 and conducted in accord with CFR 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the MCO.

6.5.4.3. DSHS will provide a copy of the EQRR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, enrollees and potential enrollees of the Contractor, recipient advocacy groups, and members of the general public. DSHS must make this information available in alternative formats for persons with sensory impairments, when requested.

6.5.4.4. If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to DSHS. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with DSHS, Department of Health (DOH), and Health Care Authority (HCA) as needed to reduce duplicated work for both the Contractor and the state.

6.6. **Enrollee Mortality:** The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to DSHS upon request. The Contractor shall assist DSHS in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.7. **Practice Guidelines:** The Contractor shall adopt practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 CFR 438.236):

6.7.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

6.7.2. Consider the needs of enrollees and support client and family involvement in care plans;

6.7.3. Are adopted in consultation with contracting health care professionals;

6.7.4. Are reviewed and updated at least every two years and as appropriate;

6.7.5. Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees; and

6.7.6. Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

6.8. **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to DSHS for review and approval by January 31st of each year of this Contract. The formulary shall be submitted to:

Siri Childs, Pharm D, Pharmacy Policy Manager (or her successor)
Department of Social and Health Services
Division of Medical Management
P.O. Box 45506
Olympia, WA 98504-5506

childsa@dshs.wa.gov

7. **SUBCONTRACTS**

7.1. **Contractor Remains Legally Responsible**: Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract. However, no subcontract shall terminate the Contractor's legal responsibility to DSHS for any work performed under this Contract (42 CFR 434.6 (c)).

7.2. **Solvency Requirements for Subcontractors**: For any subcontractor at financial risk, as described in Section 8.8.3. Substantial Financial Risk, or Section 1.17. Risk, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

7.3. **Provider Nondiscrimination**:

7.3.1. The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.

7.3.2. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

7.3.3. The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).

7.3.4. Consistent with the Contractors responsibilities to the enrollees, this Section may not be construed to require the Contractor to Contract with providers beyond the number necessary to meet the needs of its enrollees; preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

7.4. **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

7.4.1. Identification of the parties of the subcontract and their legal basis for operation in the State of Washington.

7.4.2. Procedures and specific criteria for terminating the subcontract.

7.4.3. Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

7.4.4. Reimbursement rates and procedures for services provided under the subcontract.

7.4.5. Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

7.4.6. Reasonable access to facilities and financial and medical records for duly authorized representatives of DSHS or DHHS for audit purposes, and immediate access for Medicaid fraud investigators.

7.4.7. The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to comply with the Encounter Data Transaction Guide published by DSHS.

7.4.8. The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

7.4.9. No assignment of the subcontract shall take effect without the DSHS' written agreement.

7.4.10. The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this Contract, including the applicable requirements of 42 CFR 438.6(1).

7.4.11. Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract.

7.4.12. The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):

7.4.12.1. The toll-free numbers to file oral grievances and appeals.

7.4.12.2. The availability of assistance in filing.

7.4.12.3. The enrollee's right to request continuation of benefits during an appeal or fair hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits.

7.4.12.4. The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

7.4.12.5. The enrollee's right to a fair hearing, how to obtain a hearing, and representation rules at a hearing.

7.5. **Health Care Provider Subcontracts**, including those for facilities and pharmacy benefit management, shall also contain the following provisions:

7.5.1. A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

7.5.2. A statement that primary care and specialty care provider subcontractors shall cooperate with QI activities.

7.5.3. A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.

7.5.3.1. Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

7.5.3.1.1. Assigned responsibilities;

7.5.3.1.2. Delegated activities;

7.5.3.1.3. A mechanism for evaluation

7.5.3.1.4. Corrective action policy and procedure.

7.5.4. Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

7.5.5. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from DSHS or any enrollee for covered services performed under the subcontract.

7.5.6. The subcontractor agrees to hold harmless DSHS and its employees, and all enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses

which may in any manner accrue against DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

7.5.7. If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this Contract.

7.5.8. A ninety (90) day termination notice provision.

7.5.9. A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

7.5.10. The subcontractor agrees to comply with the appointment wait time standards of this Contract. The subcontract must provide for regular monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 CFR 438.206(c)(1)).

7.5.11. A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 CFR 438.230(b)).

7.6. **Health Care Provider Subcontracts Delegating Administrative Functions:** Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:

7.6.1. For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

7.6.2. Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but not limited to utilization/ medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

7.6.3. How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

7.6.4. Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate.

7.6.5. Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

7.7. **Excluded Providers:**

7.7.1. Pursuant to Section 1128 of the Social Security Act, the Contractor may not subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been: convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare and Medicaid program, assessed a civil penalty under the provisions of Section 1128, has a contractual relationship with an entity convicted of a crime specified in Section 1128, or is a person described in Section 7.26 of this Contract, Excluded Persons. The Contractor shall terminate subcontracts of excluded providers immediately with the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier.

7.7.2. In addition, if DSHS terminates a subcontractor from participation any DSHS program, the Contractor shall exclude the subcontractor from participation in Healthy Options/SCHIP. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from DSHS, whichever is earlier. Suspension of a subcontractor shall continue until DSHS notifies the Contractor that the subcontractor is no longer suspended or the subcontractor is to be terminated (WAC 388-502-0030).

7.7.3. If the Contractor terminates a subcontractor for cause, the Contractor shall notify DSHS, in writing, as provided in the Notices Section and explain the circumstances regarding the termination.

7.8. **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this Contract, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. DSHS will provide a current list of bonded home health agencies upon request to the Contractor.

7.9. **Physician Incentive Plans:** Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section in accord with federal regulations (42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210).

7.9.1. Prohibited Payments: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

7.9.2. Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by DSHS. The Contractor shall provide the following information about its

physician incentive plan, and the physician incentive plans of all its subcontractors in any tier, to the Department annually upon request:

7.9.2.1. Whether the incentive plan includes referral services.

7.9.2.2. If the incentive plan includes referral services:

7.9.2.2.1. The type of incentive plan (e.g. withhold, bonus, capitation)

7.9.2.2.2. For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

7.9.2.2.3. Proof that stop-loss protection meets the requirements of Section 8.8.4.1., including the amount and type of stop-loss protection.

7.9.2.2.4. The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military and Basic Health members.

7.9.3. Substantial Financial Risk: A physician, or physician group as defined herein, is at substantial financial risk when more than 25% of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 members arrangements that cause substantial financial risk include, but are not limited to, the following:

7.9.3.1. Withholds greater than 25% of total potential payments

7.9.3.2. Withholds less than 25% of total potential payments but the physician or physician group is potentially liable for more than 25% of total potential payments.

7.9.3.3. Bonuses greater than 33% of total potential payments, less the bonus.

7.9.3.4. Withholds plus bonuses if the withholds plus bonuses equal more than 25% of total potential payments.

7.9.3.5. Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25% of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

7.9.4. Requirements if a Physician or Physician Group is at Substantial Financial Risk: If the Contractor, or any subcontractor (e.g. IPA, PHO), places a

physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

7.9.4.1. If aggregate stop-loss protection is provided, it must cover 90% of the costs of referral services that exceed 25% of maximum potential payments under the subcontract.

7.9.4.2. If stop-loss protection is based on a per-member limit, it must cover 90% of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

7.9.4.2.1. 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

7.9.4.2.2. 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

7.9.4.2.3. 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

7.9.4.2.4. 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

7.9.4.2.5. 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

7.9.4.2.6. 25,001 members or more, there is no risk threshold.

7.9.4.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement and waive the requirement for the Contractor to conduct such surveys. DSHS shall notify the Contractor in writing if the requirement is waived. If DSHS does not waive the requirement, the Contractor shall provide the survey results to DSHS annually upon request. The surveys shall:

7.9.4.3.1. Include current enrollees, and enrollees who have disenrolled within 12 months of the survey for reasons other than loss of

Medicaid eligibility or moving outside the Contractor’s service area.

7.9.4.3.2. Be conducted according to commonly accepted principles of survey design and statistical analysis.

7.9.4.3.3. Address enrollees satisfaction with the physician or physician group’s:

7.9.4.3.3.1. Quality of services provided.

7.9.4.3.3.2. Degree of access to services.

7.9.5. Sanctions and Penalties: DSHS or CMS may impose intermediate sanctions, as described in Section 12.32, Sanctions, of this Contract, for failure to comply with the rules in this Section.

7.10. **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

7.11. **Provider Education:** The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction with the training process.

The Contractor shall maintain a system for keeping participating practitioners and providers informed about:

7.11.1. Covered services for enrollees served under this Contract;

7.11.2. Coordination of care requirements;

7.11.3. DSHS policies as related to this Contract;

7.11.4. Interpretation of data from the quality improvement program;

7.11.5. Practice guidelines (see Section 5.9).

7.12. **Claims Payment Standards:** The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95% of clean claims within thirty (30) calendar days of receipt, 95% of all claims within sixty (60) of receipt and 99% of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

7.12.1. A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

7.12.2. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

7.12.3. The date of receipt is the date the Contractor receives the claim from the provider**.**

7.12.4. The date of payment is the date of the check or other form of payment.

7.13. **FQHC/RHC Report:** The Contractor shall provide DSHS with information related to subcontracted federally-qualified health centers (FQHC) and rural health clinics (RHC), as required by the DSHS Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS (See Exhibit A for website link).

7.14. **Provider Credentialing:** The Contractor must have written policies and procedures for credentialing and recredentialing providers who have signed contracts or participation agreements with the Contractor.

7.14.1. The Contractor’s medical director or other designated physician’s shall have direct responsibility and participation in the credentialing process.

7.14.2. The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

7.14.3. Credentialing policies and procedures must specify at a minimum:

7.14.3.1. Type of providers that are credentialed and recredentialed;

7.14.3.2. Verification sources used to make credentialing decisions, including any evidence of provider sanctions; and

7.14.3.3. Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law, the Contractor’s Medical Director and participating providers.

7.14.4. The Contractor shall have criteria used to credential and recredential providers shall include:

7.14.4.1. Evidence of a current; valid license to practice

7.14.4.2. A valid DEA or CDS certificate if applicable

7.14.4.3. Evidence of education and training

7.14.4.4. Board certification if applicable

7.14.4.5. Work history

7.14.4.6. A history of liability claims resulting in settlements or judgments paid on or on behalf of the provider

7.14.5. The Contractor shall have a process for making determinations shall include a signed, dated attestation statement from the provider that addresses:

7.14.5.1. Lack of present illegal drug use;

7.14.5.2. History of loss of license and felony convictions;

7.14.5.3. History of loss or limitation of privileges or disciplinary activity;

7.14.5.4. Current malpractice coverage; and

7.14.5.5. Accuracy and completeness of the application.

7.14.6. The Contractor shall have methods for managing credentialing files;

7.14.7. The Contractor shall have a process for delegation of credentialing or recredentialing;

7.14.8. The Contractor shall have provider selection policies and procedures that are consistent with 42 CFR 438.12, and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination;

7.14.9. The Contractor shall have a process for communicating findings that differ from the provider's submitted materials, including:

7.14.9.1. Communication of the providers right to review materials

7.14.9.2. Correct incorrect or erroneous information

7.14.9.3. Be informed of their credentialing status

7.14.9.4. The ability to appeal an adverse determination by the Contractor

7.14.10. The Contractor shall have a process for notifying providers within sixty (60) days of the credentialing committee's decision;

7.14.11. The Contractor shall have a process to ensure confidentiality;

7.14.12. The Contractor shall have a process to ensure listing in provider directories for enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

7.14.13. The Contractor shall have a process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.

7.14.14. The Contractor shall have a process to ensure that offices of all primary care providers, obstetricians/gynecologists and high volume providers meet office site standards established by the Contractor.

7.14.15. A system for monitoring sanctions or limitations on licensure,, complaints and quality issues or information from identified adverse events and provides evidence of action, as appropriate based on defined methods or criteria.

8. **Enrollee Rights and Protections:**

8.1. **General Requirements**: The Contractor shall have written policies and procedures regarding all enrollee rights (42 CFR 438.100(a)(1)).

8.1.1. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2)).

8.1.2. The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):

8.1.2.1. To be treated with respect and with consideration for their dignity and privacy.

8.1.2.2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand.

8.1.2.3. To participate in decisions regarding their health care, including the right to refuse treatment.

8.1.2.4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

8.1.2.5. To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.

8.1.2.6. Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 CFR 438.100(c)).

8.2. **Cultural Considerations:** The Contractor shall participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and

diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).

8.3. **Advance Directives:**

8.3.1. The Contractor shall maintain written policies and procedures for advance directives that meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I. The Contractor's advance directive policies and procedure shall be disseminated to all affected providers, enrollees, DSHS, and, upon request, potential enrollees.

8.3.2. The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

8.3.3. Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

8.3.4. Identify the state legal authority permitting such objection.

8.3.5. Describe the range of medical conditions or procedures affected by the conscience objection.

8.3.6. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

8.3.7. The Contractor's policies and procedures must require, and the Contractor must ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive.

8.3.8. The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

8.3.9. The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives.

8.3.10. The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.

8.3.11. The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts.

8.3.12. The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

8.3.13. The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements.

8.4. **Enrollee Choice of PCP:**

8.4.1. The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP.

8.4.2. In the case of newborns, the parent shall choose the newborn's PCP.

8.4.3. If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) working days after coverage begins.

8.4.4. The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and WAC 284-43-251(1)).

8.5. **Direct Access for Enrollees with Special Health Care Needs:** The Contractor shall allow children with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a

specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this Contract demonstrates a need for a course of treatment or regular monitoring by such specialist (42 CFR 438.208 and 438.6(m)).

8.6. **Prohibition on Enrollee Charges for Covered Services:** Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for covered services in excess of the copayments DSHS implements in its fee-for-service program as referenced in Section 3.11 (SSA 1932(b)(6), SSA 1128B(d)(1)) and WAC 388-502-0160).

8.7. **Provider/Enrollee Communication:** The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following (42 CFR 438.102(a)(1)):

8.7.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

8.7.2. Any information the enrollee needs in order to decide among all relevant treatment options.

8.7.3. The risks, benefits, and consequences of treatment or non-treatment.

8.7.4. 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.

8.8. **Enrollee Self-Determination:** The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

9. **Utilization Management Program and Authorization of Services**

9.1. **Utilization Management Program:**

9.1.1. The Contractor shall have and maintain a Utilization Management Program (UMP) for the services it furnishes its enrollees.

9.1.2. The Contractor defines its UMP structure and assigns responsibility to appropriate individuals.

9.1.3. A written description of the UMP that includes identification of designated physician and behavioral health practitioner's and evidence of the physician

and behavioral health practitioner's involvement in program development and implementation The UMP program description shall include:

9.1.3.1. A written description of all UM-related committee(s);

9.1.3.2. Descriptions of committee responsibilities;

9.1.3.3. Contractor staff and practicing provider committee participant title(s);

9.1.3.4. Meeting frequency;

9.1.3.5. Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.

9.1.4. UMP behavioral health and non-behavioral health policies and procedures at minimum, shall include the following content:

9.1.4.1. Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria.

9.1.4.2. Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same.

9.1.4.3. Mechanisms for assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

9.1.4.4. Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current non-restricted license.

9.1.4.5. To detect both underutilization and over utilization of services and produce a yearly report which identifies and reports findings on utilization measures and includes completed or planned interventions to address under or over-utilization patterns of care.

9.1.4.5.1. Specify the type of personnel responsible for each level of UM decision-making.

9.1.4.5.2. A physician or behavioral health practitioner or pharmacist as appropriate reviews any behavioral health denial of care based on medical necessity.

9.1.4.5.3. Use of board certified consultants to assist in making medical necessity determinations.

9.1.4.5.4. Appeals of adverse determinations evaluated by a health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease (PBOR 284-43-620(4)).

9.1.4.6. Documentation of timelines for appeals in accord with Section 10.1.11.9.1. and 10.1.11.11.2.

9.1.5. Annually evaluate and update the UM program.

9.1.6. The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

9.1.7. The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service (PBOR 284-43-210(6)).

9.2. **Authorization of Services:** The Contractor shall have in place policies and procedures for the authorization of services that comply with 42 CFR 438.210, WAC 388-538 and the provisions of this Contract and require subcontractors with delegated authority for authorization to comply with such policies and procedures.

9.2.1. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

9.2.2. The Contractor shall consult with the requesting provider when appropriate.

9.2.3. The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

9.2.4. The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements, except that the notice to the provider need not be in writing (42 CFR 438.404):

9.2.4.1. The notice to the enrollee shall be in writing and shall meet the requirements of Section 4.7 of this Contract to ensure ease of understanding.

9.2.4.2. The notice shall explain the following:

9.2.4.2.1. The action the Contractor has taken or intends to take.

9.2.4.2.2. The reasons for the action, in easily understood language.

9.2.4.2.3. The enrollee's right to file an appeal.

9.2.4.2.4. The procedures for exercising the enrollee's rights.

9.2.4.2.5. The circumstances under which expedited resolution is available and how to request it.

9.2.4.2.6. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

9.2.5. The Contractor shall provide for the following timeframes for authorization decisions and notices:

9.2.5.1. For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

9.2.5.2. For termination, suspension, or reduction of previously authorized services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

9.2.5.3. For standard authorization decisions, a determination must be made within two business days of the receipt of necessary information and notification of the decision shall be made to the attending physician, ordering provider, facility, and enrollee within two days, (PBOR 284-43-410) but timeframes may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days under the following circumstances (42 CFR 438.210):

9.2.5.3.1. The enrollee, or the provider, requests extension; or

9.2.5.3.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

9.2.5.3.3. If the Contractor extends that timeframe, it shall:

9.2.5.3.3.1. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

9.2.5.3.3.2. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

9.2.5.4. For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. The Contractor may extend the three (3) working days by up to 14 calendar days under the following circumstances:

9.2.5.4.1. The enrollee, or the provider, requests extension; or

9.2.6. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10. **Grievance System**

10.1. **General Requirements**: The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F and WACs 388-538 and 284-43, insofar as it is not in conflict with 42 CFR 438 Subpart F. The grievance system shall include a grievance process, an appeal process, and access to the fair hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

10.1.1. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. DSHS must approve, in writing, all policies and procedures and related notices to enrollees regarding the grievance system. DSHS must also approve in writing any changes to policies and procedures.

10.1.2. The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (WAC 284-43-615(2)(e)).

10.1.3. The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days.

10.1.4. The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making.

10.1.5. Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

10.1.5.1. If the enrollee is appealing an action concerning medical necessity.

10.1.5.2. If an enrollee grievance concerns a denial of expedited resolution of an appeal.

10.1.5.3. If the grievance or appeal involves any clinical issues.

10.2. **Grievance Process**: The following requirements are specific to the grievance process:

10.2.1. Only an enrollee may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee.

10.2.2. The Contractor shall accept grievances forwarded by DSHS.

10.2.3. The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615).

10.2.4. The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615).

10.2.5. The Contractor shall investigate and resolve all grievances (WAC 284-43-615).

10.2.6. The Contractor shall complete the disposition of a grievance and notice to the affected parties within ninety (90) calendar days of receiving the grievance.

10.2.7. The Contractor may notify enrollees of the disposition of grievances orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

10.2.8. Enrollees do not have the right to a fair hearing in regard to the disposition of a grievance.

10.3. **Appeal Process**: The following requirements are specific to the appeal process:

10.3.1. An enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action.

10.3.2. If DSHS receives a request to appeal an action of the Contractor, DSHS will forward relevant information to the Contractor and the Contractor will contact the enrollee.

10.3.3. For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal.

10.3.4. For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 CFR 438.408).

10.3.5. Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution.

10.3.6. The appeal process shall provide the enrollee a 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 expedited resolution.

10.3.7. The appeal process shall provide the enrollee and the enrollee's representative 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 appeal process.

10.3.8. The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

10.3.9. The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes:

10.3.9.1. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) days after receipt of the appeal, unless the Contractor notifies the enrollee that an extension is necessary to complete the appeal; however the extension cannot delay the decision beyond thirty (30) days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.

10.3.9.2. For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

10.3.10. The notice of the resolution of the appeal shall:

10.3.10.1. Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

10.3.10.2. Include the reasons for the determination in easily understood language and the date completed.

10.3.10.3. A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision-making criteria.

10.3.10.4. For appeals not resolved wholly in favor of the enrollee:

10.3.10.4.1. Include information on the enrollee's right to request a fair hearing and how to do so.

10.3.10.4.2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

10.3.10.4.3. Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

10.4. **Expedited Appeal Process**:

10.4.1. The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

10.4.2. The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.

10.4.3. The Contractor shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

10.4.4. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

10.5. **Fair Hearing:**

10.5.1. A provider may not request a fair hearing on behalf of an enrollee.

10.5.2. If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a fair hearing within the following time frames (see WAC 388-538-112 for the fair hearing process for enrollees):

10.5.2.1. For fair hearings regarding a standard service, within ninety (90) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal.

10.5.2.2. For fair hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for fair hearing regarding a standard service apply.

10.5.3. If the enrollee requests a fair hearing, the Contractor shall provide to DSHS upon request and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

10.5.4. The Contractor is an independent party and is responsible for its own representation in any fair hearing, independent review, Board of Appeals and subsequent judicial proceedings.

10.5.5. The Contractor's medical director or designee shall review all cases where a fair hearing is requested and any related appeals, when medical necessity is an issue.

10.5.6. The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a fair hearing with DSHS.

10.5.7. DSHS will notify the Contractor of fair hearing determinations. The Contractor will be bound by the fair hearing determination, whether or not the fair hearing determination upholds the Contractor's decision. Implementation of such fair hearing decision shall not be the basis for disenrollment of the enrollee by the Contractor.

10.5.8. If the fair hearing decision is not within the purview of this Contract, then DSHS will be responsible for the implementation of the fair hearing decision.

10.6. **Independent Review**: After exhausting both the Contractor's appeal process and the fair hearing process an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-43-630.

10.7. **Board of Appeals:** An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the DSHS Board of Appeals in accord with WAC ###-##-#### through ###-##-####. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.

10.8. **Continuation of Services**:

10.8.1. The Contractor shall continue the enrollee's services if all of the following apply:

10.8.1.1. An appeal, fair hearing or independent review is requested on or before the later of the following:

10.8.1.1.1. Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

10.8.1.1.2. The intended effective date of the Contractor's proposed action.

10.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

10.8.1.3. The services were ordered by an authorized provider.

10.8.1.4. The original period covered by the original authorization has not expired.

10.8.1.5. The enrollee requests an extension of services.

10.8.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, fair hearing, independent review or DSHS Board of Appeals is pending, the services shall be continued until one of the following occurs:

10.8.2.1. The enrollee withdraws the appeal, fair hearing or independent review request.

10.8.2.2. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a fair hearing (with continuation of services until the fair hearing decision is reached) within the ten (10) calendar days.

10.8.2.3. Ten (10) calendar days pass after DSHS mails the notice of resolution of the fair hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

10.8.2.4. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollees has not requested a DSHS Board of Appeals (with continuation of services until the DSHS Board of Appeals decision is reached) within ten (10) calendar days.

10.8.2.5. The time period or service limits of a previously authorized service has been met.

10.8.3. If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

10.9. **Effect of Reversed Resolutions of Appeals and Fair Hearings**:

10.9.1. If the Contractor, DSHS Office of Administrative Hearings (OAH), independent review organization (IRO) or DSHS Board of Appeals reverses a decision to deny, limit, or delay services that were not provided 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.

10.9.2. If the Contractor, OAH, IRO or DSHS Board of Appeals 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.

10.10. **Actions, Grievances, Appeals and Independent Reviews:** The Contractor shall maintain records of all actions, grievances, appeals and independent reviews of adverse appeal decisions by an independent review organization.

10.10.1. The records shall include actions, grievances and appeals handled by delegated entities.

10.10.2. The Contractor shall provide a report of complete actions, grievances, appeals and independent reviews to DSHS biannually for the prior six months.

10.10.2.1. The report for the six months ending March 31st is due no later than June 1st.

10.10.2.2. The report for the six months ending September 30th is due no later than November 1st.

10.10.3. The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities.

10.10.4. Delegated actions, grievances and appeals are to be integrated into the Contractor's report.

10.10.5. Data shall be reported in the DSHS and Contractor agreed upon format.

10.10.6. The report medium shall be specified by DSHS.

10.10.7. Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the enrollee may be liable for payment.

10.10.8. The Contractor shall provide information to DSHS regarding denial of payment to providers upon request.

10.10.9. Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action.

10.10.10. The records shall include, at a minimum:

10.10.10.1. Plan Name

10.10.10.2. Name of the delegated entity, if any

10.10.10.3. Quarter of occurrence

10.10.10.4. Name of Program: HO, SCHIP, or BH+

10.10.10.5. Enrollee Identifier - Patient Identification Code (PIC)

10.10.10.5.1. Enrollee Last Name

10.10.10.5.2. Enrollee First Name

10.10.10.5.3. Enrollee Middle Initial

10.10.10.5.4. Enrollee Birthday

10.10.10.6. Provider Last Name

10.10.10.7. Provider First Name

10.10.10.8. Provider Middle Initial

10.10.10.9. Provider Category (Optional)

10.10.10.10. Provider Category Code (Optional)

10.10.10.11. Type/Level:

10.10.10.11.1. Type 1 Grievance

10.10.10.11.2. Type 3 Action

10.10.10.11.3. Type 4 Appeal - First Level

10.10.10.11.4. Type 5 Appeal - Second Level

10.10.10.11.5. Type 6 IRO

10.10.10.12. Expedited: Yes or No

10.10.10.13. Grievance, Appeal or Requested Service Denied Category

10.10.10.14. Grievance or Requested Service Denied Category Code

10.10.10.15. Grievance or Action Reason Type

10.10.10.16. Grievance or Action Reason Type Code

10.10.10.17. Resolution of Grievance, Appeal or IRO

10.10.10.18. Date Received

10.10.10.19. Date of Resolution

10.10.10.20. Resolution Code

10.10.10.21. Date written notification of Action or Grievance, Appeal or IRO outcome sent to enrollee and provider

11. BENEFITS

11.1. Scope of Services:

11.1.1. The Contractor is responsible for covering medically necessary services relating to:

11.1.1.1. The prevention, diagnosis, and treatment of health impairments.

11.1.1.2. The achievement age-appropriate growth and development.

11.1.1.3. The attainment, maintenance, or regaining of functional capacity.

11.1.2. If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program, as described in DSHS' billing instructions, (See Exhibit A for website link) the Contractor shall cover the service subject to the specific exclusions and limitations as described in this Contract.

11.1.3. Except as otherwise specifically provided in this Contract, the Contractor shall provide covered services in the amount, duration and scope described in the Medicaid State Plan.

11.1.4. The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

11.1.5. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition.

11.1.6. Except as specifically provided in Section 10.18, Authorization of Services, this shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary covered services to enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee for service program.

11.1.7. For specific covered services, this shall also not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

11.1.8. Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of services covered under this Contract.

11.1.9. The Contractor may limit coverage of services to participating providers except as specifically provided in Section 4, Access and Capacity; Section 11, Benefits, for emergency services; as necessary to provide medically necessary services as described in Section 10.1.2. Out of Service Area; and as necessary to coordinate benefits under the requirements of Section 3.8. Third Party Liability when an enrollee has other medical coverage.

11.1.10. Within the Service Areas: Within the Contractor's service areas, as defined in Section 2.1, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this Contract.

11.1.11. Outside the Service Areas: For the enrollees still enrolled with the Contractor who are temporarily outside of the service areas or who have

moved to a service area not served by the Contractor, the Contractor shall cover the following services:

11.1.11.1. Emergency and post-stabilization services.

11.1.11.2. Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require pre-authorization for urgent care services as long as the wait times specified in Section 4.4, Appointment Standards, are not exceeded.

11.1.11.3. Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e. preventive care) out of the service area. The Contractor may require pre-authorization for such services as long as the wait times specified in Section 4.4, Appointment Standards, are not exceeded.

11.1.11.4. The Contractor's obligation for services outside the service area is limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee leaves the service area or changes residence.

11.1.11.5. The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

11.2. **Medical Necessity Determination:** The Contractor shall determine which services are medically necessary, according to utilization management requirements and the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding appeals, fair hearings and independent review.

11.3. **Enrollee Self-Referral:**

11.3.1. Enrollees have the right to self-refer for certain services to local health departments and family planning clinics paid through separate arrangements with the State of Washington.

11.3.2. The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

11.3.3. The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the

Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor.

11.3.4. If the Contractor subcontracts with local health departments or family planning clinics as participating providers or refers enrollees to them to receive services, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

11.3.5. The services to which an enrollee may self-refer are:

11.3.5.1. Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

11.3.5.2. Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through the local health department.

11.4. **Women's Health Care Services:** The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractors network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

11.5. **Maternity Newborn Length of Stay:** The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

11.6. **Continuity of Care:** The Contract shall ensure the Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted (42 CFR 438.208).

11.6.1. For changes in the Contractor's provider network or service areas, the Contractor shall comply with the provisions of Sections 2.1.3.3 and 4.11.2.

11.6.2. If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

11.6.3. Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

11.6.4. The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

11.6.4.1. The thirtieth (30^{th}) calendar day after enrollment with the Contractor.

11.6.4.2. The enrollee's prescription expires.

11.6.4.3. A participating provider examines the enrollee to evaluate the continued need for the prescription.

11.7. **Coordination of Care:** The Contractor shall ensure that health care services are coordinated for enrollees as follows (42 CFR 438.208):

11.7.1. The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care.

11.7.2. The Contractor shall also provide or shall ensure PCPs provide ongoing coordination of community-based services required by enrollees, including but not limited to:

11.7.2.1. First Steps Maternity Services and Maternity Case Management,

11.7.2.2. Transportation services,

11.7.2.3. Regional Support Networks for mental health services,

11.7.2.4. Developmental Disability services, including the Infant Toddler Early Intervention Program (ITEIP),

11.7.2.5. Health Department services, including Title V services for children with special health care needs,

11.7.2.6. Home and Community Services for older and physically disabled individuals,

11.7.2.7. Alcohol and Substance Abuse services

11.7.3. The Contractor shall provide support services to assist PCPs in providing coordination if it is not provided directly by the Contractor.

11.7.4. The Contractor shall ensure that enrollee health information is shared between providers in a manner that facilitates coordination of care while protecting confidentiality and enrollee rights.

11.7.5. The Contractor shall identify or shall ensure that providers identify enrollees with special health care needs as defined in WAC 388-538-050. The Contractor's obligation for identification of enrollees with special health care needs is limited to identification in the course of any health care visit initiated by the enrollee.

11.7.6. The Contractor shall ensure that PCPs, in consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs and enrollees with special health care needs as defined herein, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

11.7.6.1. Documentation regarding the assessment and treatment plan shall be in the enrollee's case file, including enrollee participation in the development of the treatment plan.

11.7.6.2. If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.

11.8. **Second Opinions:**

11.8.1. The Contractor must authorize a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or authorize for the enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for a qualified health care professional, at no cost to the enrollee.

11.8.2. This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider (42 CFR 438.206(b)(3)).

11.9. **Sterilizations and Hysterectomies:** The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

11.10. **Experimental and Investigational Services:**

11.10.1. If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed to be experimental or investigational, the Contractor shall develop and follow policies and procedures for such exclusions and limitations. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to DSHS upon request (WAC's 284-44-043, 284-46-507 and 284-96-015).

11.10.2. In making the determination, whether a service is experimental and investigational and, therefore, not a covered service, the Contractor shall consider the following:

11.10.2.1. Evidence in peer-reviewed, medical literature, as defined herein, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications.

11.10.2.2. Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

11.10.2.3. Any relevant, specific aspects of the condition.

11.10.2.4. Whether the service or treatment is generally used for the condition in the State of Washington.

11.10.2.5. Whether the service or treatment is under continuing scientific testing and research.

11.10.2.6. Whether the service or treatment shows a demonstrable benefit for the condition.

11.10.2.7. Whether the service or treatment is safe and efficacious.

11.10.2.8. Whether the service or treatment will result in greater benefits for the condition than another generally available service.

11.10.2.9. If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

11.10.3. Criteria to determine whether a service is experimental or investigational shall be no more stringent for Medicaid enrollees than that applied to any other members.

11.10.4. A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

11.10.5. A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

11.10.6. An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, including independent review, through the fair hearing process and independent review.

11.11. **Enrollee Hospitalized at Enrollment:**

11.11.1. If an enrollee is enrolled in Healthy Options/SCHIP on the day the enrollee was admitted to an acute care hospital, then the plan the enrollee is enrolled with on the date of admission shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

11.11.2. Except as provided in Section 3.6.4., for newborns born while their mother is hospitalized, the party responsible for the payment for the mother's hospitalization shall be responsible for payment of all inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital.

11.11.3. For newborns who are disenrolled retroactive to the date of birth and whose premiums are recouped as provided herein, DSHS shall be responsible for payment of all inpatient facility and professional services provided to and associated with the newborn. The provisions of 3.6.1. or 3.6.2. shall apply for services provided to and associated with the mother.

11.11.4. If DSHS is responsible for payment of all inpatient facility and professional services provided to a mother, DSHS shall not pay the Contractor a Delivery Case Rate under the provisions of Section 3.2.

11.12. **Enrollee Hospitalized at Disenrollment:** If an enrollee is in an acute care hospital at the time of disenrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date the enrollee is no longer confined to an acute care hospital.

11.13. **General Description of Covered Services:** This Section is a general description of services covered under this Contract and is not intended to be exhaustive.

11.13.1. Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency or mental health diagnosis are covered when those services are otherwise covered services.

11.13.2. Inpatient Services: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18-51) when nursing facility services are not covered by the Department's Aging and Disability Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

11.13.3. Outpatient Hospital Services: Provided by acute care hospitals (licensed under RCW 70.41).

11.13.4. Emergency Services and Post-stabilization Services:

11.13.4.1. Emergency Services: Emergency services are defined herein.

11.13.4.1.1. The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

11.13.4.1.2. The Contractor shall cover all emergency services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.13.4.1.3. Emergency services shall be provided without requiring prior authorization.

11.13.4.1.4. What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(i)).

11.13.4.1.5. The Contractor shall cover treatment obtained under the following circumstances:

11.13.4.1.5.1. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

11.13.4.1.5.2. A participating provider or other Contractor representative instructs the enrollee to seek emergency services.

11.13.4.1.6. If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

11.13.4.2. Post-stabilization Services: Post-stabilization services are defined herein.

11.13.4.2.1. The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

11.13.4.2.2. The Contractor shall cover all post-stabilization services provided by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or non-participating provider.

11.13.4.2.3. The Contractor shall cover post-stabilization services under the following circumstances:

11.13.4.2.3.1. The services are pre-approved by a participating provider or other Contractor representative.

11.13.4.2.3.2. The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

11.13.4.2.3.3. The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and:

11.13.4.2.3.3.1. The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

11.13.4.2.3.3.2. The Contractor cannot be contacted; or

11.13.4.2.3.3.3. 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 care of the enrollee until a Contractor physician is reached or one of the criteria in Section 11.1.6.2.4. is met.

11.13.4.2.4. The Contractor's responsibility for post-stabilization services it has not pre-approved ends when:

11.13.4.2.4.1. A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

11.13.4.2.4.2. A participating provider assumes responsibility for the enrollee's care through transfer;

11.13.4.2.4.3. A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

11.13.4.2.4.4. The enrollee is discharged.

11.13.5. Ambulatory Surgery Center: Services provided at ambulatory surgery centers.

11.13.6. Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians. Provider Services include, but are not limited to:

11.13.6.1. Medical examinations, including wellness exams for adults and EPSDT for children

11.13.6.2. Immunizations

11.13.6.3. Maternity care

11.13.6.4. Family planning services provided or referred by a participating provider or practitioner

11.13.6.5. Performing and/or reading diagnostic tests

11.13.6.6. Private duty nursing

11.13.6.7. Surgical services

11.13.6.8. Services to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

11.13.6.9. Anesthesia

11.13.6.10. Administering pharmaceutical products

11.13.6.11. Fitting prosthetic and orthotic devices

11.13.6.12. Rehabilitation services

11.13.6.13. Enrollee health education

11.13.6.14. Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia.

11.13.7. Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

11.13.8. Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

11.13.9. Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

11.13.10. Outpatient Mental Health:

11.13.10.1. Psychiatric and psychological testing, evaluation and diagnosis:

11.13.10.1.1. Once every twelve (12) months for adults twenty-one (21) and over

11.13.10.1.2. Unlimited for children under age twenty-one (21) when identified in an EPSDT visit

11.13.10.2. Unlimited medication management:

11.13.10.2.1. Provided by the PCP or by PCP referral

11.13.10.2.2. Provided in conjunction with mental health treatment covered by the Contractor

11.13.10.3. Twelve hours per calendar year for treatment for enrollees who do not meet the RSN's access standards for receiving treatment.

11.13.10.4. Transition to the RSN, as appropriate to the enrollee's condition to assure continuity of care.

11.13.10.5. The Contractor may subcontract with RSN's to provide the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

11.13.10.6. The DSHS Mental Health Division (MHD) and the Division of Program Support (DPS) shall each appoint a Mental Health Care Coordinator (MHCC). The MHCC's shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCC's will also undertake training and technical assistance activities that further coordination of care between DPS, MHD, Healthy Options contractors, and RSN's. The Contractor shall cooperate with the activities of the MHCC's.

11.13.11. Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a

function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a DSHS recognized neurodevelopmental center. The Contractor may refer children to a DSHS recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met (See Exhibit A for website link).

11.13.12. Pharmaceutical Products: Prescription drug products according to a Department approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall have policies and procedures for the administration of the pharmacy benefit including formulary exceptions. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request. Covered drug products shall include:

11.13.12.1. Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas;

11.13.12.2. All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products;

11.13.12.3. Antigens and allergens; and

11.13.12.4. Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

11.13.13. Home Health Services: Home health services through state-licensed agencies.

11.13.14. Durable Medical Equipment (DME) and Supplies: Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

11.13.15. Oxygen and Respiratory Services: Oxygen, and respiratory therapy equipment and supplies.

11.13.16. Hospice Services: When the enrollee elects hospice care. Includes facility services.

11.13.17. Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

11.13.18. Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

11.13.19. Ambulance Transportation: The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

11.13.19.1. When it is necessary to transport an enrollee between facilities to receive a covered services; and,

11.13.19.2. When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

11.13.20. Smoking Cessation Services: For pregnant women through sixty (60) calendar days post pregnancy.

11.13.21. Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health as of January 1, 2006.

11.13.22. EPSDT:

11.13.22.1. The Contractor shall meet all requirements under the DSHS EPSDT program policy and billing instructions (See Exhibit A for website link).

11.13.22.2. The following services are cover when referred as a result of an EPSDT exam:

11.13.22.2.1. Chiropractic services;

11.13.22.2.2. Nutritional counseling; and

11.13.22.2.3. Unlimited psychiatric and psychological testing evaluation and diagnosis.

11.14. **Exclusions:** The following services and supplies are excluded from coverage under this agreement. Unless otherwise required by this agreement, ancillary services resulting from excluded services are also excluded. Complications resulting from an excluded service are also excluded for a period of one hundred

and eighty (180) calendar days following the occurrence of the excluded service not counting the date of service, except for complication resulting from surgery for weight loss or reduction, which are excluded for a period of three hundred and sixty-five (365) calendar days following the occurrence of the excluded service not counting the date of service. Thereafter, complications resulting from an excluded service are a covered service when they would otherwise be a covered service under the provisions of this agreement.

11.14.1. Services Covered By DSHS Fee-For-Service Or Through Other Contracts:

11.14.1.1. School Medical Services for Special Students as described in the DSHS billing instructions for School Medical Services.

11.14.1.2. Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

11.14.1.3. Voluntary Termination of Pregnancy.

11.14.1.4. Transportation Services other than Ambulance: including but not limited to Taxi, cabulance, voluntary transportation, public transportation and common carriers.

11.14.1.5. Dental Care, Prostheses, Orthodontics and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery and anesthesia for dental care.

11.14.1.6. Hearing Aid Devices, including fitting, follow-up care and repair.

11.14.1.7. First Steps Maternity Case Management and Maternity Support Services.

11.14.1.8. Sterilizations for enrollees under age 21, or those that do not meet other federal requirements (42 CFR 441 Subpart F) (See Exhibit A for website link).

11.14.1.9. Health care services provided by a neurodevelopmental center recognized by DSHS.

11.14.1.10. Services provided by a health department or family planning clinic when a client self-refers for care.

11.14.1.11. Inpatient psychiatric professional services.

11.14.1.12. Emergency mental health services.

11.14.1.13. Pharmaceutical products prescribed by any provider related to services provided under a separate Contract with DSHS or related to services not covered by the Contractor.

11.14.1.14. Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.

11.14.1.15. Protease Inhibitors.

11.14.1.16. Services ordered as a result of an EPSDT exam that are not otherwise covered services.

11.14.1.17. Surgical procedures for weight loss or reduction, when approved by DSHS in accord with WAC 388-531-0200. The Contractor has no obligation to cover surgical procedures for weight loss or reduction.

11.14.1.18. Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered only for pregnant women as maternity care when medically necessary, see Section 11.1.8.3.

11.14.2. Services Covered By Other Divisions In The Department Of Social And Health Services:

11.14.2.1. Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA).

11.14.2.2. Community-based services (e.g. COPES and Personal Care Services) covered through the Aging and Disability Services Administration.

11.14.2.3. Nursing facilities covered through the Aging and Disability Services Administration.

11.14.2.4. Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, Club House, respite care, Supported Employment and inpatient psychiatric services.

11.14.2.5. Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

11.14.2.6. Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

11.14.3. Services Not Covered by Either DSHS or the Contractor:

11.14.3.1. Medical examinations for Social Security Disability.

11.14.3.2. Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

11.14.3.3. Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

11.14.3.4. Sports physicals.

11.14.3.5. Experimental and Investigational Treatment or Services, determined in accord with Section 10.16, Experimental and Investigational Services, and services associated with experimental or investigational treatment or services.

11.14.3.6. Reversal of voluntary induced sterilization.

11.14.3.7. Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

11.14.3.8. Biofeedback Therapy.

11.14.3.9. Massage Therapy.

11.14.3.10. Acupuncture.

11.14.3.11. TMJ for Adults.

11.14.3.12. Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

11.14.3.13. Orthoptic (eye training) care for eye conditions.

11.14.3.14. Naturopathy.

11.14.3.15. Tissue or organ transplants that are not specifically listed as covered.

11.14.3.16. Immunizations required for international travel purposes only.

11.14.3.17. Court-ordered services.

11.14.3.18. Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody.

11.14.3.19. Any service, product, or supply paid for by DSHS under its fee-for-service program only on an exception to policy basis.

11.14.3.20. Any other service, product, or supply not covered by DSHS under its fee-for-service program.

11.15. **Coordination of Benefits and Subrogation of Rights of Third Party Liability:**

11.15.1. Coordination of Benefits:

11.15.1.1. Until such time as DSHS shall terminate the enrollment of an enrollee who has comparable coverage as described in Section 2.9.3., the services and benefits available under this Contract shall be secondary to any other medical coverage.

11.15.1.2. Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement of Section 10.13., Prohibition on Enrollee Charges for Covered Services. The Contractor shall:

11.15.1.2.1. Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

11.15.1.2.2. Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

11.15.1.2.3. Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

11.15.1.2.4. Pay claims for covered services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

11.15.1.2.5. Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

11.15.2. Subrogation Rights of Third-Party Liability:

11.15.2.1. Injured person means an enrollee covered by this Contract who sustains bodily injury.

11.15.2.2. Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

11.15.2.3. If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

11.15.2.4. DSHS specifically assigns to the Contractor the DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

11.15.2.5. DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

11.15.2.6. The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

11.15.2.7. The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

12. GENERAL TERMS AND CONDITIONS

12.1. **Amendment:** This Contract, or any term or condition, may be modified or extended by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

12.2. **Assignment of this Contract:** The Contractor shall not assign this Contract, including the rights, benefits and duties hereunder, without obtaining the express written consent of DSHS. DSHS shall not recognize any assignment made without such prior written consent. In the event that consent is given and this Contract is assigned, all terms and conditions of this Contract shall be binding upon the Contractor's successors and assignees.

12.3. **Access to Facilities and Records:** The Contractor and its subcontractors shall cooperate with audits performed by duly authorized representatives of the State of Washington, the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall

provide access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, the quality, cost, use and timeliness of services (42 CFR 434.52), and assessment of the Contractor's capacity to bear the potential financial losses (42 CFR 434.58). The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this Contract for Medicaid fraud investigators.

12.4. **Compliance with All Applicable Laws and Regulations:** In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract (42 CFR 438.100(d)). This includes, but is not limited to:

12.4.1. Title XIX and Title XXI of the Social Security Act;

12.4.2. Title VI of the Civil Rights Act of 1964;

12.4.3. Title IX of the Education Amendments of 1972, regarding any education programs and activities;

12.4.4. The Age Discrimination Act of 1975;

12.4.5. The Rehabilitation Act of 1973;

12.4.6. All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

12.4.6.1. All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS, and the EPA.

12.4.6.2. Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

12.4.6.3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

12.4.6.4. Those specified in Title 18 RCW for professional licensing.

12.4.6.5. Industrial Insurance – Title 51 RCW.

12.4.6.6. Reporting of abuse as required by RCW 26.44.030.

12.4.6.7. Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2.

12.4.6.8. EEO Provisions

12.4.6.9. Copeland Anti-Kickback Act.

12.4.6.10. Davis-Bacon Act.

12.4.6.11. Byrd Anti-Lobbying Amendment.

12.4.6.12. All federal and state nondiscrimination laws and regulations.

12.4.6.13. Americans with Disabilities Act: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

12.4.6.14. Any other requirements associated with the receipt of federal funds.

12.5. **Complete Contract:** This Contract incorporates Exhibits to this Contract and the DSHS billing instructions applicable to the Contractor. All terms and conditions of this Contract are stated in this Contract and its incorporations. No other agreements, oral or written, are binding.

12.6. **Confidentiality:** The Contractor may use Personal Information and other information gained by reason of this Contract only for the purpose of this Contract. The Contractor shall not disclose, transfer or sell any such information to any party, including but not limited to medical records, except as provided by law or, in the case or Personal Information, with the prior written consent of the person to whom the Personal Information pertains or their legal guardian. The Contractor shall maintain and protect the confidentiality of all Personal Information and other information gained by reason of this Contract. Upon written request by DSHS, the Contractor shall either return or destroy and certify destruction of all Personal Information.

12.6.1. The Contractor and DSHS agree to share information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164., the HIPAA regulations, 42 CFR 431 Subpart F, RCW 5.60.060(4), and RCW 70.02). The Contractor and the Contractor's subcontractors shall fully cooperate with DSHS efforts to implement HIPAA requirements.

12.6.2. Retained client data shared by DSHS with the Contractor, due to the confidentiality of the information, must be maintained throughout the life

cycle of the data, to include any record retention cycle, or archival period, in a manner that will retain its confidential nature regardless of the age or media format of the data.

12.7. **Contractor Certification Regarding Ethics:** The Contractor certifies that the Contractor is now, and shall remain, in compliance with Chapter 42.52 RCW, Ethics in Public Services, throughout the term of this Contract.

12.8. **Covenant Against Contingent Fees:** The Contractor promises that no person or agency has been employed or retained on a contingent fee for the purpose of seeking or obtaining this Contract. This does not apply to legitimate employees or an established commercial or selling agency maintained by the Contractor for the purpose of securing business. In the event of breach of this clause by the Contractor, DSHS may, at its discretion: a) annul the Contract without any liability; or b) deduct from the Contract price or consideration or otherwise recover the full amount of any such contingent fee.

12.9. **Data Certification Requirements**: Any information and/or data required by this Contract and submitted to DSHS after April 1, 2005 shall be certified by the Contractor as follows (42 CFR 438.600 through 42 CFR 438.606):

12.9.1. Source of certification: The information and/or data shall be certified by one of the following:

12.9.1.1. The Contractor's Chief Executive Officer

12.9.1.2. The Contractor's Chief Financial Officer

12.9.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer

12.9.2. Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

12.9.3. Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

12.9.4. Data that must be certified include documents specified by DSHS and include enrollment information, encounter data and other information contained in contracts or proposals, as required by DSHS.

12.10. **Disputes:** When a dispute arises over an issue that pertains in any way to this Contract, the parties agree to the following process to address the dispute:

12.10.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and the Office Chief of the DSHS, Division of Program Support, Office of Managed Care.

12.10.2. If the Contractor is not satisfied with the outcome of the resolution with the Office Chief, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the outcome, to:

MaryAnne Lindeblad, Director (or her successor)
Department of Social and Health Services
Division of Program Support
P.O. Box 45530
Olympia, WA 98504-5530

The Director may request additional information from the Office Chief and/or the Contractor. The Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor according to Section 7. .

12.10.3. When the Contractor disagrees with the review decision of the Director, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the Director, in writing, within ten (10) working days of the contractor's receipt of the Director's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

12.10.4. Both parties agree to make their best efforts to resolve disputes arising from this Contract and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this Contract.

12.10.5. DSHS Not Guarantor: The Contractor acknowledges and certifies that neither DSHS nor the State of Washington are guarantors of any obligations or debts of the Contractor.

12.11. **Excluded Persons:**

12.11.1. The Contractor may not knowingly have a director, officer, partner, or person with a beneficial ownership of more than 5% of the Contractor's equity, or have an employee, consultant or contractor who is significant or material to the provision of services under this Contract, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d)(1)). A list of excluded parties in available on the following Internet website: www.arnet.gov/epls.

12.11.2. By entering into this Contract, the Contractor certifies that it does not knowingly have anyone who is an excluded person, or is affiliated with an excluded person, as a director, officer, partner, employee, contractor, or person with a beneficial ownership of more than 5% of its equity. The

Contractor is required to notify DSHS when circumstances change that affect such certification.

12.11.3. The Contractor is not required to consult the excluded parties list, but may instead rely on certification from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than 5% of the Contractor's equity, that they are not debarred or excluded from a federal program.

12.12. **Five Percent Equity**: The Contractor shall provide to DSHS, according to Section 7. , Notices, a list of persons with a beneficial ownership of more than 5% of the Contractor's equity no later than February 28th of each year of this Contract.

12.13. **Force Majeure**: If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent DSHS from terminating this Contract for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

12.14. **Fraud and Abuse Requirements – Policies and Procedures:**

12.14.1. The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse (42 CFR 438.608(a)).

12.14.2. The Contractor's arrangements or procedures shall include the following (42 CFR 438.608(b)(1)):

12.14.2.1. Written policies, procedures, and standards of conduct that articulates the Contractor's commitment to comply with all applicable federal and state standards.

12.14.2.2. The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.14.2.3. Effective training for the compliance officer and the Contractor's employees.

12.14.2.4. Effective lines of communication between the compliance officer and the Contractor's staff.

12.14.2.5. Enforcement of standards through well-publicized disciplinary guidelines.

12.14.2.6. Provision for internal monitoring and auditing.

12.14.2.7. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.14.3. The Contractor shall submit a written copy of its administrative and management arrangement or procedures and mandatory compliance plan regarding fraud and abuse to DSHS for approval, according to Section 7. , Notices, by March 31st each year of this Contract. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The Contractor shall have thirty (30) calendar days to resubmit the policies and procedures. If the administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse have been approved by DSHS for the previous year and they are unchanged, the Contractor shall not be required to resubmit them but instead shall certify in writing to DSHS that they are unchanged, in accord with Section 7.0, Notices.

12.14.4. The Contractor may request a copy of the guidelines that DSHS will use in evaluating the Contractor's written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, and may request technical assistance in preparing the written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, by contacting the DSHS, Office of Managed Care e-mail box at healthyoptions@dshs.wa.gov.

12.15. **Fraud and Abuse Reporting:** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days to DSHS according to Section 7.4, Notices. The report shall include the following information:

12.15.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.

12.15.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.

12.15.3. Nature of complaint.

12.15.4. Estimate of the amount of funds involved.

12.15.5. Legal and administrative disposition of case.

12.16. **Governing Law and Venue:** This Contract shall be governed by the laws of the State of Washington. In the event of any action brought hereunder, venue shall be proper only in Thurston County, Washington. By execution of this Contract,

the Contractor acknowledges the jurisdiction of the courts of the State of Washington regarding this matter.

12.17. **Headings not Controlling:** The headings and the index used herein are for reference and convenience only, and shall not enter into the interpretation thereof, or describe the scope or intent of any provisions or sections of this Contract.

12.18. **Health and Safety:** The Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any DSHS client with whom the Contractor has contact.

12.19. **Health Information Systems:** The Contractor shall maintain and shall require subcontractors to maintain a health information system that complies with the requirements of 42 CFR 438.242 and provides the information necessary to meet the Contractor's obligations under this Contract. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The health information system must:

12.19.1. Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

12.19.2. Ensure data received from providers is accurate and complete by:

12.19.2.1. Verifying the accuracy and timeliness of reported data;

12.19.2.2. Screening the data for completeness, logic, and consistency; and

12.19.2.3. Collecting service information on standardized formats to the extent feasible and appropriate.

12.19.3. The Contractor shall make all collected data available to DSHS and the Center for Medicare and Medicaid Services (CMS) upon request.

12.20. **Independent Contractor:** The Contractor acknowledges that the Contractor is an independent Contractor, and certifies that none of its directors, officers, partners, employees, or agents are officers, employees, or agents of DSHS or the State of Washington. Neither the

Contractor nor any of its directors, officers, partners, employees, or agents shall hold themselves out as, or claim to be, an officer, employee, or agent of DSHS or the State of Washington by reason of this Contract. Neither the Contractor nor any of its directors, officers, partners, employees, or agents shall claim any rights, privileges, or benefits that would accrue to a civil service employee under RCW 41.06.

12.20.1. Contractor shall be responsible for the payment of its internal administrative costs, including but not limited to federal, state and social security tax payments. The Contractor shall indemnify and hold DSHS harmless from all obligations to pay or withhold federal or state taxes or contributions on

behalf of the Contractor or the Contractor's employees.

12.21. **Information on Outstanding Claims at Termination:** In the event this agreement is terminated, the Contractor shall provide DSHS, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of Section 3, Payment.

12.22. **Insolvency:**

12.22.1. If the Contractor becomes insolvent during the term of this Contract:

12.22.1.1. The State of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor;

12.22.1.2. In accord with Section , Prohibition on Enrollee Charges for Covered Services, under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for covered services.

12.22.1.3. The Contractor shall, in accord with RCW 48.44.055, or RCW 48.46.425, provide for the continuity of care for enrollees.

12.23. **Insurance:** The Contractor shall at all times comply with the following insurance requirements:

12.23.1. Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this Contract.

12.23.2. Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

12.23.3. Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and DSHS shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

12.23.4. Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

12.23.5. Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to DSHS if requested.

12.23.6. Separation of Insureds: All insurance Commercial General Liability policies shall contain a "separation of insureds" provision.

12.23.7. Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the State of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by the DSHS. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

12.23.8. Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the notices section of this Contract, Section , for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

12.23.9. Material Changes: The Contractor shall give DSHS, in accord with the Notices Section of this Contract, 45 days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give DSHS 10 days advance notice of cancellation.

12.23.10. General: By requiring insurance, the State of Washington and DSHS do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and DSHS in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

Contractor may waive the requirements contained in Section , , and if self-insured. In the event the Contractor is self insured, the Contractor must send to DSHS by January 15, 2006, a signed written document, which certifies that the contractor is self insured, carries coverage adequate to meet the requirements of Section 7.28, will treat DSHS as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for DSHS.

12.24. **Mutual Indemnification and Hold Harmless**: East party shall be responsible for, and shall indemnify and hold the other party harmless from, all claims and/or damages to persons and/or property resulting from its own all negligent acts and omissions. The Contractor shall indemnify and hold harmless DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this Contract.

12.24.1. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

12.25. **No Federal or State Endorsement**: Award of this Contract does not indicate endorsement of the Contractor by CMS, the federal or state government or any similar entity. No federal funds have been used for lobbying purposes in connection with this Contract or managed care program.

12.26. **Notices**:

12.26.1. Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if mailed by United States Postal Services, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

12.26.2. In the case of notice to the Contractor, notice will be sent to the point of contact submitted to DSHS on the Contractor Intake Form.

In the case of notice to DSHS:

Peggy Wilson, Office Chief (or successor)
Department of Social and Health Services
Division of Program Support
Office of Managed Care
P.O. Box 45530
Olympia, WA 98504-5530

Said notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accord with this Section, stating the change and setting forth the new address, which shall be effective on the tenth day following the effective date of such notice unless a later date is specified.

12.27. **Order of Precedence**: In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

12.27.1. Title XIX of the federal Social Security Act of 1935, as amended, and its implementing regulations, as well as federal statutes and regulations concerning the operation of Managed Care Organizations;

12.27.2. State of Washington statues and regulations concerning the operation of the DSHS programs participating in this Contract, including but not limited to chapters 388-538 (Managed Care), 388-865 (Mental Health) and 388-805 (DASA) WAC.

12.27.3. State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers;

12.27.4. The terms and conditions of this Contract;

12.27.5. Exhibits, if any, as indicated on page one of this Contract;

12.27.6. DSHS solicitation documents associated with this Contract;

12.27.7. Any other material incorporated herein by reference.

12.28. **Pre-termination**:

12.28.1. Dispute Resolution: If the Contractor disagrees with a DSHS decision to terminate this Contract, other than a termination for convenience, the Contractor will have the right to a dispute resolution as described in Section Disputes.

12.28.2. Pre-termination Hearing and Procedures: If the dispute process is not successful, DSHS shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. DSHS shall:

12.28.2.1. Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

12.28.2.2. Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

12.28.2.3. For an affirming decision, given enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

12.29. **Program Information**: At the Contractor's request, DSHS shall provide the Contractor with pertinent documents including statutes, regulations, and current versions of billing instructions and other written documents which describe DSHS policies and guidelines related to service coverage and reimbursement (See Exhibit A for website link).

12.30. **Proprietary Rights**: DSHS recognizes that nothing in this Contract shall give DSHS ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by DSHS during the performance of this Contract.

12.31. **Records Maintenance and Retention**:

12.31.1. Maintenance: The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

12.31.2. Retention: All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

12.31.3. Review of Client Information: DSHS agrees to provide the Contractor with copies of written client information, which DSHS intends to distribute to clients.

12.32. **Sanctions**:

12.32.1. If the Contractor fails to meet one or more of its obligations under the terms of this Contract, DSHS may impose sanctions by withholding up to five percent of its scheduled payments to the Contractor rather than terminating the Contract.

DSHS may withhold payment from the end the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

12.32.2. DSHS will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in Section 7. , if the Contractor disagrees with DSHS' position.

12.32.3. DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for:

12.32.3.1. Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an enrollee covered under this Contract.

12.32.3.2. Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract;

12.32.3.3. Acting 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 an enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services;

12.32.3.4. Misrepresenting or falsifying information that it furnishes to CMS or to the DSHS;

12.32.3.5. Failing to comply with the requirements for physician incentive plans;

12.32.3.6. Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by DSHS or that contain false or materially misleading information.

12.32.3.7. Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

12.32.3.8. Intermediate sanctions may include:

12.32.3.8.1. Civil monetary penalties in the following amounts:

12.32.3.8.1.1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations;

12.32.3.8.1.2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or DSHS;

12.32.3.8.1.3. A maximum of $15,000 for each potential enrollee DSHS determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit;

12.32.3.8.1.4. A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under WMIP. DSHS will deduct from the penalty the amount charged and return it to the enrollee.

12.32.3.8.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. DSHS will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033.

12.32.3.8.3. Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. DSHS shall notify current enrollees of the sanctions and that they may terminate enrollment at any time.

12.32.3.8.4. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DSHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

12.33. **Severability**: The terms and conditions of this Contract are severable. If any term or condition of this Contract is held invalid by any court, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

12.34. **Solvency**:

12.34.1. The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapter 48.44 or 48.46 RCW, as amended.

12.34.2. The Contractor agrees that DSHS may at any time access any information related to the Contractor's financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.

12.35. **State Conflict of Interest Safeguards**: The Contractor shall have conflict of interest safeguards, at least equal to federal safeguards (41 USC 423).

12.36. **Survivability**:

12.36.1. The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Confidentiality, Indemnification and Hold Harmless, Access to Facilities and Records, and Maintenance of Records.

12.36.2. After termination of this Contract, the Contractor remains obligated to:

12.36.2.1. Cover hospitalized enrollees until discharge consistent with Section .

12.36.2.2. Submit reports required in Section , Reporting;

12.36.2.3. Provide access to records required in Section 7. .

12.36.2.4. Provide the administrative services associated with covered services (e.g. claims processing, enrollee appeals) provide to enrollees under the terms of this Contract.

12.37. **Termination for Convenience**: Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this Contract in whole or in part, whenever, for any reason, either party determines that such termination is in its best interest.

12.37.1. In the event DSHS terminates this Contract for convenience, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs. Such claim must be:

12.37.1.1. Delivered to DSHS as provided in Section 7. , Notices;

12.37.1.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of Section , Termination by DSHS for Default, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this Section. DSHS may extend said ninety (90) calendar days if the Contractor makes a written request to DSHS and DSHS deems the grounds for the request to be reasonable. DSHS will evaluate

the claim for termination costs and either pay or deny the claim. DSHS shall notify the Contractor of DSHS' decision within sixty (60) calendar days of receipt of the claim.

12.37.2. In the event the Contractor terminates this Contract for convenience, DSHS shall have the right to assert a claim for DSHS' direct termination costs. Such claim must be:

12.37.2.1. Delivered to the Contractor as provided in Section 7. Notices;

12.37.2.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The Contractor may extend said ninety (90) calendar days if DSHS makes a written request to the Contractor and the Contractor deems the grounds for the request to be reasonable.

12.37.2.3. The Contractor shall evaluate the claim for termination costs and either pay or deny the claim. The Contractor shall notify DSHS of the Contractor's decision within sixty (60) calendar days of receipt of the claim.

12.37.3. In the event the Contractor or DSHS disagrees with the decision entered by the other party pursuant to this Section, the Contractor or DSHS shall have the right to a dispute resolution as described in Section 7. Disputes.

12.37.4. In no event shall the claim from termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.

12.37.5. In addition to DSHS' or Contractor's direct termination costs, the Contractor or DSHS shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.

12.37.6. Neither the Contractor nor DSHS shall be liable for any termination costs if it notifies the other party of its intent not to renew this Contract at least one hundred twenty (120) calendar days prior to the renewal date.

12.37.7. In the event this Contract is terminated for the convenience of either party, the effective date of termination shall be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.

12.38. **Termination by the Contractor for Default**: The Contractor may terminate this Contract whenever DSHS defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice specifying the default. For purposes of this section, default means failure to meet one or more material obligations of this Contract. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction. The procedure for determining damages shall be as stated in Section .

12.39. **Termination by DSHS for Default**: The Contract Administrator may terminate this Contract whenever the Contractor shall default in performance of this Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice specifying the default. For purposes of this section, default means failure to meet one or more material obligations of this Contract. In the event it is determined that DSHS was not in default, DSHS may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction. The procedure for determining damages shall be as stated in Section .

12.40. **Termination for Reduction in Funding**: In the event funding from state, federal, or other sources is withdrawn, reduced or limited in any way after the effective date of this Contract and prior to the termination date, DSHS may terminate this Contract under the "Termination for Convenience" clause.

12.41. **Terminations - Pre-termination Processes:**

12.41.1. DSHS shall give the Contractor written notice of the intent to terminate this Contract and the reason for termination.

12.41.2. If the Contractor disagrees with a DSHS decision to terminate this Contract, other than a termination for convenience, the Contractor will have the right to a dispute resolution as described in Section , Disputes.

12.41.3. If the dispute resolution process is not successful, DSHS shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. DSHS shall notify the Contractor in writing of the time and place of the hearing;

12.41.4. Within thirty (30) calendar days after the hearing DSHS shall give the Contractor written notification of the decision affirming or reversing the proposed termination of the Contract, and if the termination is upheld, provide the effective date of termination.

12.41.5. If the termination is upheld, DSHS shall give enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

12.41.6. Pre-termination Dispute Resolution: If the Contractor disagrees with a DSHS decision to terminate this Contract, other than a termination for convenience, the Contractor will have the right to a dispute resolution as described in Section Disputes.

12.41.7. Pre-termination Hearing and Procedures: If the dispute process is not successful, DSHS shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. DSHS shall:

12.41.7.1. Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

12.41.7.2. Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

12.41.7.3. For an affirming decision, give enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

12.42. **Washington Public Disclosure Act**: The Contractor acknowledges that DSHS is subject to the Public Records Act (the Act, which is codified at RCW 42.17.250, et seq.) This Contract will be a 'public record' as defined in RCW 42.17.020. Any documents submitted to DSHS by the Contractor may also be construed as 'public records' and therefore subject to public disclosure under the Act. The Contractor may label documents submitted to DSHS as 'confidential' or

'proprietary' if it so chooses; however, the Contractor acknowledges that such labels are not determinative of whether the documents are subject to disclosure under the Act. If DSHS receives a public disclosure request that would encompass any Contractor document that has been labeled by the Contractor as 'confidential' or 'proprietary', then DSHS will notify the Contractor pursuant to RCW 42.17.330. The Contractor then will have the option, under RCW 42.17.330, of seeking judicial intervention to prevent the public disclosure of the affected document(s).

12.43. **Waiver**: The failure of either party to enforce any provision of this Contract shall not constitute a waiver of that or any other provision, and will not be construed to be a modification of the terms and conditions of the Contract unless incorporated into the Contract by an amendment.

HEALTH CARE AUTHORITY (HCA)

2006 – 2007 CONTRACT

FOR

BASIC HEALTH PLUS

AND

MATERNITY BENEFITS PROGRAM

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

TABLE OF CONTENTS

		Page
1.	**DEFINITIONS**	1
1.1	**Action**	1
1.2	**Advance Directive**	1
1.3	**Ancillary Services**	1
1.4	**Appeal**	1
1.5	**Appeal Process**	1
1.6	**Basic Health Plus and Maternity Benefits Program (BH)**	1
1.7	**Children With Special Health Care Needs**	1
1.8	**Cold Call Marketing**	1
1.9	**Comparable Coverage**	1
1.10	**Consumer Assessment of Health Plans Survey (CAHPS®)**	1
1.11	**Continuity of Care**	2
1.12	**Coordination of Care**	2
1.13	**Covered Services**	2
1.14	**Duplicate Coverage**	2
1.15	**EPSDT**	2
1.16	**Eligible Clients**	2
1.17	**Emergency Medical Condition**	2
1.18	**Emergency Services**	2
1.19	**Enrollee**	2
1.20	**Enrollee with Special Health Care Needs**	3
1.21	**External Quality Review (EQR)**	3
1.22	**External Quality Review Organization (EQRO)**	3
1.23	**External Quality Review Protocols**	3
1.24	**External Quality Review Report - (EQRR)**	3
1.25	**Grievance**	3
1.26	**Grievance Process**	3
1.27	**Grievance System**	3
1.28	**Health Care Professional**	3
1.29	**Health Employer Data and Information Set - (HEDISâ)**	4
1.30	**Health Employer Data and Information Set (HEDISâ) Compliance Audit Program**	4
1.31	**Managed Care**	4
1.32	**Managed Care Organization (MCO)**	4
1.33	**Marketing**	4
1.34	**Marketing Materials**	4
1.35	**Medically Necessary Services**	4
1.36	**National CAHPS® Benchmarking Database - (NCBD)**	4
1.37	**National Committee for Quality Assurance - (NCQA)**	5
1.38	**Participating Provider**	5
1.39	**Peer-Reviewed Medical Literature**	5
1.40	**Physician Group**	5
1.41	**Physician Incentive Plan**	5
1.42	**Post-stabilization Services**	5

1.43	**Potential Enrollee**	5
1.44	**Primary Care Provider (PCP)**	5
1.45	**Quality**	6
1.46	**Risk**	6
1.47	**Service Areas**	6

1.48 State Children's Health Insurance Program (SCHIP) 6
1.49 Subcontract 6
1.50 Validation 6
2. ENROLLMENT 6
2.1 Service Areas 6
2.2 Eligible Client Groups 7
2.3 Client Notification 7
2.4 Exemption from Enrollment 8
2.5 Enrollment Period 8
2.6 Enrollment Process 8
2.7 Effective Date of Enrollment 8
2.8 Enrollment Listing and Requirements for Contractor's Response 9
2.9 Termination of Enrollment 9
2.10 Enrollment Not Discriminatory 12
3. MARKETING AND INFORMATION REQUIREMENTS 12
3.1 Marketing 12
3.2 Information Requirements for Enrollees and Potential Enrollees 13
3.3 Equal Access for Enrollees & Potential Enrollees with Communication Barriers 16
4. PAYMENT 18
4.1 Rates/Premiums 18
4.2 Delivery Case Rate Payment 20
4.3 Renegotiation of Rates 20
4.4 Reinsurance/Risk Protection 20
4.5 Recoupments 20
4.6 Rate Setting Methodology 21
4.7 Information for Rate Setting 21
4.8 Payments to Critical Access Hospitals (CAH) 21
4.9 Stop Loss for Hemophiliac Drugs 22
4.10 Encounter Data 22
5. ACCESS 22
5.1 Network 22
5.2 Service Delivery Network 23
5.3 Timely Access to Care 23
5.4 Hours of Operation for Network Providers 23
5.5 24/7 Availability 24
5.6 Appointment Standards 24
5.7 Integrated Provider Network Database (IPND) 24
5.8 Provider Network-Distance Standards 24
5.9 Standards for Specialty and Primary Care Providers 25
5.10 Access to Specialty Care 26
5.11 Order of Acceptance 26

5.12 Provider Network Changes 26
6. QUALITY OF CARE 26
6.1 Quality Assessment and Performance Improvement (QAPI) Program 26
6.2 Performance Improvement Projects 28
6.3 Performance Measures using Health Employer Data & Information Set (HEDISâ) 29
6.4 Consumer Assessment of Health Plans Survey (CAHPS®) 32
6.5 External Quality Review 34
6.6 Enrollee Mortality 35
6.7 Practice Guidelines 36
6.8 Drug Formulary Review and Approval 36
7. SUBCONTRACTS 36
7.1 Contractor Remains Legally Responsible 36
7.2 Solvency Requirements for Subcontractors 36
7.3 Provider Nondiscrimination 37
7.4 Required Provisions 37
7.5 Health Care Provider Subcontracts 38
7.6 Health Care Provider Subcontracts Delegating Administrative Functions 40
7.7 Excluded Providers 40
7.8 Home Health Providers 41
7.9 Physician Incentive Plans 41
7.10 Payment to FQHCs/RHCs 44
7.11 Provider Education 44
7.12 Claims Payment Standards 44
7.13 FQHC/RHC Report 45
7.14 Provider Credentialing 45
8. ENROLLEE RIGHTS AND PROTECTIONS 47
8.1 General Requirements 47
8.2 Cultural Considerations 47
8.3 Advance Directives 47
8.4 Enrollee Choice of PCP 49

8.5 Direct Access for Enrollees with Special Health Care Needs 49
8.6 Prohibition on Enrollee Charges for Covered Services 50
8.7 Provider/Enrollee Communication 50
8.8 Enrollee Self-Determination 50
9. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES 50
9.1 Utilization Management Program 50
9.2 Authorization of Services 52
10. GRIEVANCE SYSTEM 54
10.1 General Requirements 54
10.2 Grievance Process 55
10.3 Appeal Process 56
10.4 Expedited Appeal Process 57
10.5 Hearings 58
10.6 Independent Review 59
10.7 Board of Appeals 59
10.8 Continuation of Services 59

10.9 Effect of Reversed Resolutions of Appeals and Fair Hearings 60
10.10 Actions, Grievances, Appeals and Independent Reviews 61
11. BENEFITS 63
11.1 Scope of Services 63
11.2 Medical Necessity Determination 65
11.3 Enrollee Self-Referral 65
11.4 Women's Health Care Services 66
11.5 Maternity Newborn Length of Stay 66
11.6 Continuity of Care 66
11.7 Coordination of Care 66
11.8 Second Opinions 68
11.9 Sterilizations and Hysterectomies 68
11.10 Experimental and Investigational Services 68
11.11 Enrollee Hospitalized at Enrollment 69
11.12 Enrollee Hospitalized at Disenrollment 70
11.13 General Description of Covered Services 70
11.14 Exclusions 76
11.15 Coordination of Benefits and Subrogation of Rights of Third Party Liability 80
12. GENERAL TERMS AND CONDITIONS 81
12.1 Amendment 81
12.2 Assignment of this Contract 81
12.3 Access to Facilities and Records 82
12.4 Compliance with All Applicable Laws and Regulations 82
12.5 Complete Contract 83
12.6 Confidentiality 83
12.7 Contractor Certification Regarding Ethics 85
12.8 Covenant Against Contingent Fees 85
12.9 Data Certification Requirements 85
12.10 Disputes 86
12.11 HCA and DSHS Not Guarantor 87
12.12 Exclusions and Debarment 87
12.13 Five Percent Equity 87
12.14 Force Majeure 87
12.15 Fraud and Abuse Requirements–Policies and Procedures 88
12.16 Fraud and Abuse Reporting 89
12.17 Governing Law and Venue 89
12.18 Headings not Controlling 89
12.19 Health and Safety 89
12.20 Health Information Systems 89
12.21 Independent Contractor 90
12.22 Insolvency 90
12.23 Insurance 91
12.24 Mutual Indemnification and Hold Harmless 92
12.25 No Federal or State Endorsement 92
12.26 Notices 92
12.27 Order of Precedence 93

12.28 Program Information 94
12.29 Proprietary Rights 94
12.30 Records Maintenance and Retention 94
12.31 Sanctions 94

12.32	**Severability**	96
12.33	**Solvency**	96
12.34	**State Conflict of Interest Safeguards**	97
12.35	**Survivability**	97
12.36	**Termination by the Contractor for Default**	97
12.37	**Termination by HCA for Default**	97
12.38	**Termination for Reduction in Funding**	98
12.39	**Termination - Information on Outstanding Claims**	98
12.40	**Terminations-Pre-termination Processes**	98
12.41	**Washington Public Disclosure Act**	98
12.42	**Waiver**	99

Attachment A **Schedule of Events and Website References**

Exhibit A **Premiums, Service Areas and Capacity**

1. DEFINITIONS

The following definitions shall apply to this Contract:

1.1 **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).

1.2 **Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of Washington, relating to the provision of health care when an individual is incapacitated (WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I).

1.3 **Ancillary Services** means health care services which are auxiliary, accessory, or secondary to a primary health care service.

1.4 **Appeal** means a request for review of an action (42 CFR 438.400(b)).

1.5 **Appeal Process** means the Contractor's procedures for reviewing an action.

1.6 **Basic Health Plus and Maternity Benefits Program (BH)** means a federal aid medical care program jointly administered by the HCA and Washington State Department of Social and Health Services (DSHS) for certain children and pregnant women as set forth in Eligible Client Groups, Section 2.2, of this agreement.

1.7 **Children with Special Health Care Needs** means children identified by DSHS to the Contractor as children served under the provisions of Title V of the Social Security Act.

1.8 **Cold Call Marketing** means any unsolicited personal contact by the Contractor or its designee, with a potential enrollee or an enrollee with another BH or Healthy Options/State Children's Health Insurance Program (HO/SCHIP) contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

1.9 **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.

1.10 **Consumer Assessment of Health Plans Survey (CAHPS®)** means a commercial and Medicaid standardized survey instrument used to measure client experience of health care.

1.11 **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions in providers or service areas, between BH or HO/SCHIP contractors and between Medicaid fee-for-service and BH or HO/SCHIP in a manner that does not interrupt medically necessary care or jeopardize the enrollee's health.

1.12 **Coordination of Care** means the Contractor's mechanisms to assure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services (42 CFR 438.208).

1.13 **Covered Services** means medically necessary services, as set forth in Section 11, Benefits, covered under the terms of this Contract.

1.14 **Duplicate Coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under BH.

1.15 **EPSDT** (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r) and the DSHS EPSDT program policy and billing instructions (see Attachment A for website link). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance

abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. EPSDT services covered by the Contractor are described in Section 11, Benefits.

1.16 **Eligible Clients** means Medicaid recipients certified eligible by DSHS, living in the service area, and eligible to enroll for health care services under the terms of this Contract, as described in Section 2.2.

1.17 **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: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).

1.18 **Emergency Services** means covered inpatient and outpatient services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)).

1.19 **Enrollee** means a Medicaid recipient who is enrolled in BH managed care through a Managed Care Organization (MCO) having a Contract with HCA (42 CFR 438.10(a)).

1.20 **Enrollee with Special Health Care Needs** means an enrollee who has chronic and disabling condition as defined in WAC 388-538-050.

1.21 **External Quality Review (EQR)** means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to Medicaid recipients (42 CFR 438.320).

1.22 **External Quality Review Organization (EQRO)** means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both (42 CFR 438.320).

1.23 **External Quality Review Protocols** means a series of nine (9) procedures or guidelines for validating performance. Two of the nine protocols must be used by state Medicaid agencies. These are: 1) Determining Contractor compliance with federal Medicaid managed care regulations; and 2) Validation of performance improvement projects undertaken by the Contractor. The current External Quality Review Protocols can be found at the Centers for Medicare and Medicaid Services (CMS) website (see Attachment A for website link).

1.24 **External Quality Review Report - (EQRR)** means a technical report that describes the manner in which the data from all EQR activities are aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor. DSHS will provide a copy of the EQRR to the Contractor, through print or electronic media.

1.25 **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).

1.26 **Grievance Process** means the procedure for addressing enrollees' grievances.

1.27 **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the hearing system (42 CFR 438, Subpart F).

1.28 **Health Care Professional** means a physician or any of the following acting within their scope of practice; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, pharmacist and certified respiratory therapy technician (42 CFR 438.2).

1.29 **Health Employer Data and Information Set - (HEDISâ)** means a set of standardized performance measures designed to ensure that healthcare purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDISâ are related to many significant public health issues such as immunizations, smoking, asthma, and diabetes. HEDISâ also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDISâ is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

1.30 **Health Employer Data and Information Set (HEDISâ) Compliance Audit Program** means a set of standards and audit methods used by an NCQA certified auditor to evaluate information systems capabilities assessment (IS standards) and a Contractor's ability to comply with HEDISâ specifications (HD standards).

1.31 **Managed Care** means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.

1.32 **Managed Care Organization (MCO)** means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to Eligible Clients under the BH managed care programs.

1.33 **Marketing** means any communication from the Contractor to a potential enrollee or enrollee with another BH contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either to not enroll in, or to disenroll from, another BH or DSHS contracted MCO (CFR 438.104(a)).

1.34 **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).

1.35 **Medically Necessary Services** means services that are "medically necessary" as is defined in WAC 388-500-0005. In addition, medically necessary services shall include services related to the enrollee's ability to achieve age-appropriate growth and development.

1.36 **National CAHPS® Benchmarking Database - (NCBD)** means a national repository for data from the Consumer Assessment of Health Plans Survey (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also

offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.

1.37 **National Committee for Quality Assurance - (NCQA)** means an organization responsible for developing and managing health care measures that assess the quality of care and services that commercial and Medicaid managed care clients receive.

1.38 **Participating Provider** means a person, health care provider, practitioner, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this Contract.

1.39 **Peer-Reviewed Medical Literature** means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.40 **Physician Group** means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

1.41 **Physician Incentive Plan** means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this Contract.

1.42 **Post-stabilization 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 (42 CFR 438.114 and 42 CFR 422.113).

1.43 **Potential Enrollee** means any Medicaid recipient eligible for enrollment in BH who is not enrolled with a health care plan having a contract with HCA (42 CFR 438.10(a)).

1.44 **Primary Care Provider (PCP)** means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

1.45 **Quality** means the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 CFR 438.320).

1.46 **Risk** means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined herein.

1.47 **Service Areas** means the geographic areas covered by this Contract as described in Section 2.1.

1.48 **State Children's Health Insurance Program (SCHIP)** means a program to provide access to medical care for children whose family income exceeds the limit for Medicaid eligibility, but is not greater than two hundred fifty percent (250%) of the federal poverty level (FPL). SCHIP is authorized by Title XXI of the Social Security Act and by RCW 74.09.450 (WAC 388-542).

1.49 **Subcontract** means a written agreement between the Contractor and a subcontractor, or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this Contract.

1.50 **Validation** means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis (42 CFR 438.320).

2. ENROLLMENT

2.1 **Service Areas:**

2.1.1 The Contractor's service areas are described in Exhibit A, Premiums and Service Areas. HCA may modify Exhibit A, Premiums and Service Areas, for service area changes as described in Section 2.1.3 herein.

2.1.2 Clients in the eligibility groups described in Section 2.2 are eligible to enroll with the Contractor if they reside in the Contractor's service areas. HCA may require Contractor to cover full ZIP codes that cross county borders served by Contractor in order to assure continuity of care or ready access to health care services. Enrollees may be required by Contractor to access care in the county where Contractor has been awarded a contract even though the enrollee's residence may be in the portion of the ZIP code which crosses the county line.

2.1.3 Service Area Changes:

2.1.3.1 The Contractor shall not change its Service Area without prior approval of the HCA. With the written approval of HCA, the Contractor may expand into additional service areas at any time by giving written notice to HCA and DSHS, along with evidence, as HCA may require, demonstrating the Contractor's ability to support the expansion. HCA may withhold approval of a requested expansion, if, in HCA's sole judgment, the requested expansion is not in the best interest of HCA.

2.1.3.2 The Contractor shall notify enrollees affected by any service area decrease sixty (60) calendar days prior to the effective date. Notices shall by approved in advance by HCA and DSHS. If the Contractor fails to notify affected enrollees of a service area decrease sixty (60) calendar days prior to the effective date, the decrease shall not be effective until the first day of the month which falls sixty (60) calendar days from the date the Contractor notifies enrollees.

2.1.4 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

2.1.5 HCA shall determine, in its sole judgment, which zip codes fall within each service area. No zip code will be split between service areas.

2.1.6 HCA will determine whether an enrollee resides within a service area.

2.2 **Eligible Client Groups**: DSHS shall determine eligibility for enrollment under this Contract. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract, and must enroll in BH unless the enrollee has comparable coverage as defined herein, or is exempted pursuant to Section 2.4.

2.2.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families and clients who are not eligible for cash assistance who remain eligible for Medicaid.

2.2.2 Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act ("H" Children).

2.2.3 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act ("S" women).

2.3 **Client Notification:** HCA shall notify eligible clients of their rights and responsibilities as BH enrollees at the time of initial eligibility determination and

at least annually. The Contractor shall provide enrollees with additional information as described in this Contract.

2.4 **Exemption from Enrollment:** A client may request exemption from enrollment. Each request for exemption will be reviewed by DSHS pursuant to WAC 388-538 or WAC 388-542. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a disenrollment request consistent with the provisions of Section 2.9.

2.5 **Enrollment Period:** Subject to the provisions of Section 2.7, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one BH plan to another without cause, each month.

2.6 **Enrollment Process:** To enroll with the Contractor, the client, the client's representative or responsible parent or guardian must complete and submit a BH application to HCA.

2.7 **Effective Date of Enrollment:**

2.7.1 Except for newborns, enrollment with the Contractor shall be effective on the later of the following dates:

2.7.1.1 If the enrollment is processed on or before the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the month following the month in which the enrollment is processed; or

2.7.1.2 If the enrollment is processed after the DSHS cut-off date for enrollment, enrollment shall be effective the first day of the second month following the month in which the enrollment is processed.

2.7.2 Newborns whose mothers are enrollees shall be deemed enrollees and enrolled beginning from the newborn's date of birth or the mother's date of enrollment, whichever is later. If the mother is disenrolled before the newborn receives a separate client identifier from DSHS, the newborn's coverage shall end when the mother's coverage ends, except as provided in Section 11.11, Enrollee Hospitalized at Disenrollment. If the newborn does not receive a separate client identifier by the sixtieth (60th) day of life, supplemental premiums and coverage shall only be available through the end of the month in which the sixtieth (60th) day of life falls in accord with Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS (see Attachment A for website link).

2.7.3 Adopted children shall be covered consistent with the provisions of Title 48 RCW.

2.7.4 No retroactive coverage is provided under this Contract, except as described in this Section.

2.8 **Enrollment Listing and Requirements for Contractor's Response:**

2.8.1 Before the end of each month, HCA will provide the Contractor with a data file with the information needed to perform the health care services described in the Contract necessary for managed care enrollees.

2.8.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834 Benefit Enrollment and Maintenance format.

2.8.2.1 The data file, in the 834 benefit enrollment and maintenance format, will list the enrollees whose enrollment is terminated by the end of that month, and the enrollees for the following month with the Contractor.

2.8.2.2 The data file will include but not be limited to the following enrollee personal information: Name, address, SSN, age/sex, ethnicity, race and language markers.

2.8.3 The Contractor shall have ten (10) calendar days from the receipt of the enrollment listing to notify HCA and DSHS in writing of the refusal of an application for enrollment or any discrepancy regarding DSHS' proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by DSHS. The effective date of enrollment specified by DSHS shall be considered accepted by the Contractor and shall be binding if the notice is not timely or DSHS does not agree with the reasons stated in the notice. Subject to DSHS approval, the Contractor may refuse to accept an enrollee for the following reasons:

2.8.3.1 HCA has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted for (with the exception of those zip codes that may cross county borders, pursuant to the terms set forth in section 2.1.2 of this agreement).

2.8.3.2 The enrollee is not eligible for enrollment under the terms of this Contract.

2.9 **Termination of Enrollment**:

2.9.1 Voluntary Termination: Enrollees may request termination of enrollment by submitting a written request to terminate enrollment to HCA or by calling the BH toll-free enrollment number. Requests for termination of enrollment may be made to enroll with another BH or Healthy Options plan, or to disenroll from BH as provided in WAC 388-538 or WAC 388-542. Except as provided in WAC 388-538 or WAC 388-542, enrollees whose enrollment is terminated will be prospectively disenrolled. HCA shall notify the Contractor of enrollee terminations pursuant to Section 2.8. The Contractor may not request voluntary disenrollment on behalf of an enrollee.

2.9.2 Involuntary Termination Initiated by DSHS for Ineligibility: The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

2.9.2.1 When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

2.9.2.1.1 The first day of the month following the month in which the termination is processed by DSHS if the termination is processed on or before the DSHS cut-off date for enrollment or the Contractor is informed by HCA or DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.1.2 Effective the first day of the second month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment and the Contractor is not informed by DSHS of the termination prior to the first day of the month following the month in which the termination is processed by DSHS.

2.9.2.2 Enrollees Eligible for Social Security Income (SSI):

2.9.2.2.1 Newborn enrollees with a date of birth after calendar year 2003 who are determined by the Social Security Administration (SSA) to have an SSI eligibility effective date within the first sixty (60 days of life, not counting the birth date, shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the State Data Exchange (SDX). Such newborn enrollees will be disenrolled retroactively effective the date of birth. DSHS shall recoup premiums paid in accord with Section 4.5.1.5.

2.9.2.2.2 Except as provided in Section 2.9.2.2.1, enrollees determined by the SSA to be eligible for SSI shall be ineligible for services under the terms of this Contract when DSHS receives the SSI eligibility information from the SSA through the electronic SDX. Such enrollees will be disenrolled prospectively as described in Section 2.9.2.1. Neither HCA nor DSHS shall recoup any premiums for enrollees determined SSI eligible and the Contractor shall be responsible for providing services under the terms of this Contract until the effective date of disenrollment.

2.9.2.2.3 If the Contractor believes an enrollee has been determined by SSA to be eligible for SSI, the Contractor shall present documentation of such eligibility to DSHS, DSHS will attempt to verify the eligibility and, if the enrollee is SSI eligible, DSHS will act upon SSI eligibility in accord with this Section.

2.9.3 Involuntary Termination Initiated by DSHS for Comparable Coverage or Duplicate Coverage:

2.9.3.1 The Contractor shall notify DSHS as set forth below when an enrollee has health care insurance coverage with the Contractor or any other carrier:

2.9.3.1.1 Within fifteen (15) working days when an enrollee is verified as having duplicate coverage, as defined herein.

2.9.3.1.2 Within sixty (60) calendar days of the date when the Contractor becomes aware that an enrollee has any health care insurance coverage with any other insurance carrier. The Contractor is not responsible for the determination of comparable coverage, as defined herein.

2.9.3.2 DSHS will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

2.9.3.2.1 When the enrollee has duplicate coverage that has been verified by DSHS, DSHS shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as describe in Section 4.5, Recoupments.

2.9.3.2.2 When the enrollee has comparable coverage which has been verified by DSHS, DSHS shall terminate enrollment effective the first day of the second month following the month in which the termination is processed if the termination is processed on or before the DSHS cut-off date for enrollment or, effective the first day of the third month following the month in which the termination is processed if the termination is processed after the DSHS cut-off date for enrollment.

2.9.4 Involuntary Termination Initiated by the Contractor: To request involuntary termination of an enrollee, the Contractor shall send written notice to HCA and DSHS as described in Section 12.26, Notices. Involuntary termination will occur only with written DSHS approval. DSHS shall review each request on a case-by-case basis, and approve or disapprove the request for termination within thirty (30) working days of receipt of such notice and the documentation required to substantiate the request. For the termination to be effective, DSHS must approve the termination request, notify the Contractor and HCA, and disenroll the enrollee. The Contractor shall continue to provide services to the enrollee until they are disenrolled. DSHS will not disenroll an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from his or her

special needs or diminished mental capacity (WAC 388-538-130). DSHS shall involuntarily terminate the enrollee when the Contractor has substantiated in writing all of the following:

2.9.4.1 The enrollee's behavior is inconsistent with the Contractor's policies and procedures addressing unacceptable enrollee behavior.

2.9.4.2 The Contractor has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the enrollee's behavior and such evaluation either finds no treatable condition to be contributing, or, after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee.

2.9.4.3 The enrollee received written notice from the Contractor of its intent to request the enrollee's disenrollment, unless the requirement for notification has been waived by DSHS because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the Contractor's grievance process to review the request to end the enrollee's enrollment.

2.9.5 An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive covered services, as described in Section 11.1, Scope of Services, at the Contractor's expense, through the end of that month.

In no event will an enrollee be entitled to receive services and benefits under this Contract after the last day of the month in which his or her enrollment is terminated, unless the enrollee is hospitalized at disenrollment; in accord with Section 11.11, Enrollee Hospitalized at Disenrollment.

2.10 **Enrollment Not Discriminatory**:

2.10.1 The Contractor will not discriminate against enrollees or potential enrollees on the basis of health status or need for health care services (42 CFR 438.6(d)(3)).

2.10.2 The Contractor will not discriminate against enrollees or potential enrollees on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 CFR 438.6(d)(4)).

3. **MARKETING AND INFORMATION REQUIREMENTS**

3.1 **Marketing:** The Contractor, and any subcontractors, shall comply with the following requirements regarding marketing (42 CFR 438.104):

3.1.1 All marketing materials must be reviewed by and have the prior written approval of HCA and DSHS prior to distribution.

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information.

3.1.3 Marketing materials must be distributed in all service areas the Contractor serves.

3.1.4 Marketing materials must be in compliance with Section 3.3, Equal Access for Enrollees and Potential Enrollees with Communication Barriers.

3.1.4.1 Marketing materials in English must give directions in the Medicaid eligible population's primary languages for obtaining understandable materials.

3.1.4.2 HCA and DSHS shall collaborate to determine, if materials that are primarily visual meet the requirements of this Contract.

3.1.5 The Contractor shall not offer anything of value as an inducement to enrollment.

3.1.6 The Contractor shall not offer the sale of other insurance to attempt to influence enrollment.

3.1.7 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

3.2 **Information Requirements for Enrollees and Potential Enrollees:**

3.2.1 The Contractor shall provide sufficient, accurate oral and written information to potential enrollees to assist them in making an informed decision about enrollment in accord with Section 3.2.5 (SSA 1932(d)(2) and 42 CFR 438.10).

3.2.2 The Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care in accord with Section 3.2.5.

3.2.3 Prior to distribution, all enrollee information shall be submitted to HCA and DSHS for written approval.

3.2.4 Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of DSHS, the change is

significant in regard to the enrollees' quality of or access to care. HCA or DSHS shall notify the Contractor of any significant change in writing.

3.2.5 The Contractor's written information to enrollees and potential enrollees shall include:

3.2.5.1 How to choose a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.5.2 How to change a PCP.

3.2.5.3 How to access services outside the Contractor's service area.

3.2.5.4 How to access Emergency Services.

3.2.5.5 General information about accessing hospital care and how to get a list of hospitals that are available to enrollees.

3.2.5.6 General information regarding specialists available to enrollees and how to obtain specific information including a list of specialists that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.5.7 How to obtain information regarding any limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP.

3.2.5.8 How to obtain information regarding Physician Incentive Plans (42 CFR 422.208 and 422.210), and information on the Contractor's structure and operations.

3.2.5.9 Informed consent guidelines.

3.2.5.10 Information regarding conversion rights under RCW 48.46.450 or RCW 48.44.370.

3.2.5.11 How to request a disenrollment.

3.2.5.12 The following information regarding advance directives:

3.2.5.12.1 A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.

3.2.5.12.2 The written policies and procedures of the Contractor concerning advance directives, including any policy that would preclude the

Contractor or subcontractor from honoring an enrollee's advance directive.

3.2.5.12.3 An enrollee's rights under state law, including the right to file a grievance with the Contractor or DSHS in accord with Section 8.3.13 regarding compliance with advance directive requirements.

3.2.5.13 How to recommend changes in the Contractor's policies and procedures.

3.2.5.14 Health promotion, health education and preventive health services available.

3.2.5.15 Information on the Contractor's Grievance System including:

3.2.5.15.1 How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential except as needed to process the grievance, appeal or independent review).

3.2.5.15.2 The enrollees' right to and how to initiate a grievance or file an appeal, in accord with the Contractor's DSHS approved policies and procedures regarding grievances and appeals.

3.2.5.15.3 The enrollees' right to and how to request a hearing after the Contractor's appeal process is exhausted, how to request a hearing and the rules that govern representation at the hearing.

3.2.5.15.4 The enrollees' right to and how to request an independent review in accord with RCW 48.43.535 and WAC 246-305 after the hearing process is exhausted and how to request an independent review.

3.2.5.15.5 The enrollees' right to appeal an independent review decision to the Board of Appeals and how to request such an appeal.

3.2.5.15.6 The requirements and timelines for grievances, appeals, hearings, independent review and Board of Appeals.

3.2.5.15.7 The enrollees' rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or a hearing.

3.2.5.15.8 The availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.

3.2.5.16 The enrollee's rights and responsibilities with respect to receiving covered services.

3.2.5.17 Information about covered benefits and how to contact DSHS regarding services that may be covered by DSHS, but are not covered benefits under this Contract.

3.2.5.18 Specific information about EPSDT.

3.2.5.19 Information regarding the availability of and how to access or obtain interpretation services and translation of written information at no cost to the enrollee.

3.2.5.20 How to obtain information in alternative formats.

3.2.5.21 The enrollee's right to and procedure for obtaining a second opinion free of charge.

3.2.5.22 The prohibition on charging enrollees for covered services and circumstances under which an enrollee might be charge for services.

3.2.6 HCA agrees to provide the Contractor with copies of written client information, which HCA intends to distribute to enrollees.

3.3 **Equal Access for Enrollees & Potential Enrollees with Communication Barriers**: The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 CFR 438.10).

3.3.1 Oral Information:

3.3.1.1 The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English, free of charge, for all interactions between the enrollee or potential enrollee and the Contractor or any of its providers including, but not limited to, customer services, all appointments with any provider for any covered service, emergency services, and all steps necessary to file grievances and appeals.

3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters including, but not limited to handling enrollee grievances and appeals.

3.3.1.3 DSHS is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.

3.3.1.4 Hospitals are responsible for payment for interpreter services during inpatient stays.

3.3.1.5 Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

3.3.1.6 Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired at no cost to the enrollee or potential enrollee (42 CFR 438.10(c)(4)).

3.3.2 Written Information:

3.3.2.1 The Contractor shall provide all generally available and client-specific written materials in a form which may be understood by each individual enrollee and potential enrollee.

3.3.2.1.1 If five percent (5%) or more of the Contractor's enrollees speak a specific language other than English, generally available materials will be translated into that language.

3.3.2.1.2 For enrollees whose primary language is not translated as required by Section 3.3.2.1.1, the Contractor may meet the requirement of this Section by doing any one of the following:

3.3.2.1.2.1 Translating the material into the enrollee's or potential enrollee's primary reading language.

3.3.2.1.2.2 Providing the material on tape in the enrollee's or potential enrollee's primary language.

3.3.2.1.2.3 Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

3.3.2.1.2.4 Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee's acceptance of the material in an alternative medium or format (42 CFR 438.10(d)(1)(ii)).

3.3.2.1.2.5 Providing the material in English, if the Contractor documents the enrollee's or potential enrollee's preference for receiving material in English.

3.3.2.2 The Contractor shall ensure that all written information provided to enrollees or potential enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade

reading level and fulfils other requirements of the Contract as may be applicable to the materials (42 CFR 438.10(b)(1) and SMD letter 02/20/98). This shall not be interpreted to include Disease Management materials, preventative services or other education materials used by the Contractor for health promotion efforts. DSHS may make exceptions to the sixth grade reading level when, in the sole judgment of DSHS, the nature of the materials do not allow for a sixth grade reading level or the enrollees' needs are better served by allowing a higher reading level. DSHS approval of exceptions to the sixth grade reading level must be in writing.

3.3.2.3 All written materials must have the written approval of DSHS prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA and DSHS. The Contractor must provide HCA and DSHS with a copy of all approved materials in final form.

4. PAYMENT

4.1 Rates/Premiums:

4.1.1 Subject to the provisions of Section 12.31, Sanctions, HCA shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this Contract. HCA shall pay the Contractor, on or before the fifteenth (15th) working day of the month based on the HCA list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.726(b) and 42 CFR 438.730(e).

4.1.2 The Contractor shall reconcile the electronic benefit enrollment listing with the premium payment information and submit a claim to DSHS for any amount due the Contractor within three hundred sixty-five (365) calendar days of the month of service. When DSHS' records confirm the Contractor's claim, DSHS shall remit payment within thirty (30) calendar days of the receipt of the claim.

4.1.3 The statewide Base Rate, Geographical Adjustment Factors, Risk Adjustment Factors and Age/Sex Factors are in Exhibit A, Premiums and Service Areas.

4.1.4 DSHS determines the BH premiums. The monthly premium payment will be calculated as follows:

Premium Payment = Base Rate x Age/Sex Factor x Risk Adjustment Factor x Geographical Adjustment Factor as described herein.

4.1.5 Within sixty (60) calendar days following the end of the annual legislative session, DSHS will publish the Base Rate for the following calendar year. If the Contractor will not continue to provide HO/SCHIP services in the following calendar year, the Contractor shall so notify DSHS no later than September 2, of the current year under the provisions of Section 12.26 Notices. If the Contractor so notifies DSHS, this Contract shall terminate, without penalty to either party, effective midnight, December 31, of the current year. In case of termination under this subsection, neither party shall have the right to assert a claim for costs.

4.1.6 The Geographical Adjustment Factors will be adjusted by DSHS for the period January 1, through December 31, of the following year for changes in utilization and to provide for the payment of Critical Access Hospitals (CAH) as required in Section 4.8, Payments to CAH. Geographical Adjustment Factors may be prospectively updated by DSHS if, in DSHS' judgment, there are material changes in rates or utilization related to CAH.

4.1.7 The Risk Adjustment Factor will be recalculated for premiums paid beginning in May for each year based on enrollment with the Contractor on March 1 of that year, using the most currently available twelve (12) months of reported encounter data. Risk Adjustment Factors may also be recalculated by DSHS if, in DSHS' sole judgment, changes in contractor participation in Medicaid Programs require rebalancing of the Risk Adjustment Factors.

4.1.8 Each year DSHS will develop a Quality Incentive based on HEDIS® measures for childhood immunizations and well child visits. If the Contractor will receive a Quality Incentive, the amount will be stated in Exhibit A, Premiums, Service Areas, and Capacity and will be paid in the first quarter of the year.

4.1.9 Notwithstanding Section 12.1, HCA may modify Exhibit A, Premiums and Service Areas, to add any changes in service areas, the Base Rate, Geographical Adjustment Factors, and Risk Adjustment Factors as needed. HCA will provide such modifications to the Contractor in writing. If the Contractor does not disagree in writing with the modifications within fifteen (15) calendar days of the date the modifications are provided, the change will amend the Contract without any further action. If the Contractor does not accept the modifications, HCA will terminate this Contract. In the case of termination under this subsection, neither party shall have the right to assert a claim for costs. If the modification changes the premium payments, the update is subject to CMS approval.

4.1.10 DSHS shall automatically generate newborn premiums whenever possible. For newborns whose premiums DSHS is not able to automatically generate the Contractor shall submit a supplemental premium payment request to DSHS within 365 calendar days of the month of service. The Contractor shall be responsible for reviewing monthly listings provided by DSHS of the

newborn premiums DSHS cannot generate automatically, as well as premium payment notices, to determine whether a supplemental premium request needs to be submitted. DSHS shall pay supplemental premiums through the end of the month in which the sixtieth (60th) day of life occurs.

4.1.11 DSHS shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided herein.

4.1.12 The Contractor shall be responsible for covered medical services provided to the enrollee in any month for which HCA or DSHS paid the Contractor for the enrollee's care under the terms of this Contract.

4.2 **Delivery Case Rate Payment:** Pursuant to Exhibit A, a one-time payment of $961.66 will be made to Contractor for prenatal and delivery expenses for persons enrolled with the Contractor during the month of delivery. In addition, a one-time payment of $4,323.60 shall be made to the Contractor for labor and delivery expenses for enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if it has incurred expenses for and paid for labor and delivery. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy. The Contractor shall submit a supplemental premium request for payment to DSHS after the enrollee delivers.

4.3 **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the Contract period only if DSHS, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation.

4.4 **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to HCA and DSHS for the services rendered.

4.5 **Recoupments:**

4.5.1 Unless mutually agreed by the parties, DSHS shall only recoup premium payments and retroactively disenroll for individual enrollees who are:

4.5.1.1 Covered by the Contractor with duplicate coverage.

4.5.1.2 Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of death.

4.5.1.3 Retroactively disenrolled as a result of the enrollee's placement in foster care.

4.5.1.4 Retroactively disenrolled consistent with the provisions of Section 2.9.1.

4.5.1.5 Newborns determined to have an SSI eligibility effective date within the first sixty (60) days of life in accord with Section 2.9.2.2.1. DSHS shall recoup all premiums paid for the enrollee, but not the birth mother, back to the month of birth.

4.5.1.6 Found ineligible for enrollment with the Contractor, provided DSHS has notified the Contractor before the first day of the month for which the premium was paid.

4.5.2 The Contractor may recoup payments made to providers for services provided to enrollees during the period for which DSHS recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to DSHS through its fee-for-service program.

4.5.3 When DSHS recoups premiums and retroactively disenrolls an enrollee, DSHS will not disenroll any other family member, except for newborns whose mother is disenrolled for duplicate coverage.

4.6 **Rate Setting Methodology:** DSHS sets actuarially-sound managed care rates that:

4.6.1 Have been developed in accord with generally accepted actuarial principles and practices;

4.6.2 Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

4.6.3 Have been certified, as meeting the requirements of 42 CFR 438.6(c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

4.7 **Information for Rate Setting:** For rate setting only, the Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. The experience information shall be provided directly to an actuary designated by DSHS. The designated actuary will determine the timing, content, format and medium for such information.

4.8 **Payments to Critical Access Hospitals (CAH):** For services provided by CAH to enrollees, the Contractor shall pay the CAH the prospective Inpatient and

Outpatient Departmental Weighted Cost-to-Charge rates published by DSHS (see Attachment A for website link).

4.9 **Stop Loss for Hemophiliac Drugs:** DSHS will provide stop loss protection for the Contractor for paid claims for Factors VII, VIII and IX and the anti-inhibitor for enrollees with a diagnosis of hemophilia as identified by diagnosis codes 286.0-286.3, V83.01 and V83.02. DSHS will reimburse the Contractor seventy-five percent (75%) of all verifiable paid claims for the identified hemophiliac drugs in excess of $250,000 for any single enrollee in any calendar year beginning January 1, 2005. The Contractor must submit documentation of paid claims as required by DSHS.

4.10 **Encounter Data:** The Contractor shall comply with the required format provided in the Encounter Data Transaction Guide published by DSHS (see Attachment A for website link). Encounter data includes claims paid by the Contractor for services delivered to enrollees through the Contractor during a specified reporting period. DSHS collects and uses this data for many reasons such as: federal reporting; rate setting and risk adjustment; service verification, managed care quality improvement program, utilization patterns and access to care; DSHS hospital rate setting; and research studies.

DSHS may change the Encounter Data Transaction Guide with one hundred and fifty (150) calendar days' written notice to the Contractor. The Encounter Data Transaction Guide may be changed with less than one hundred and fifty (150) calendar days' notice by mutual agreement of the Contractor and DSHS. The Contractor shall, upon receipt of such notice from DSHS, provide notice of changes to subcontractors.

5. ACCESS

5.1 **Network:**

5.1.1 The Contractor agrees to maintain and monitor a provider network, supported by written agreements, sufficient to serve BH enrollees in those service areas stated in Exhibit A, Premiums and Service Areas consistent with the requirements of this Contract.

5.1.2 The Contractor agrees to provide medical services required by this Contract through non-participating providers, at a cost to the enrollee that is no greater than if the services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 CFR 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.

5.1.3 The Contractor must submit documentation regarding its maintenance and monitoring of the network and services, as specified by HCA or DSHS, at any time upon request by HCA or DSHS, or when there has been a change in the Contractor's network or operations that, in the judgment of HCA or DSHS, would adversely affect adequate capacity and/or the Contractor's ability to provide services.

5.2 **Service Delivery Network:** In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 438.206(b)):

5.2.1 Adequate access to all services covered under this Contract.

5.2.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the Medicaid population represented by the Contractor's enrollees.

5.2.3 The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services.

5.2.4 The number of network providers who are not accepting new Medicaid enrollees.

5.2.5 The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by potential enrollees, and whether the location provides physical access for the Contractor's enrollees with disabilities.

5.2.6 The cultural, ethnic, race and language needs of enrollees.

5.3 **Timely Access to Care**: The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services. The Contractor shall ensure that:

5.3.1 Network providers offer access comparable to that offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Contractor serves only Medicaid enrollees (42 CFR 438.206(b)(1) & (c)(1)).

5.3.2 Mechanisms are established to ensure compliance by providers.

5.3.3 Providers are monitored regularly to determine compliance.

5.3.4 Corrective action is initiated and documented if there is a failure to comply.

5.4 **Hours of Operation for Network Providers:** The Contractor must require that network providers offer hours of operation for enrollees that are no less than the hours of operation offered to any other patient (42 CFR 438.206(c)(1)).

5.5 **24/7 Availability:** The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services may be provided directly by the Contractor or may be delegated to subcontractors (42 CFR 438.206(c)(1)(iii)).

5.5.1 Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of medical condition.

5.5.2 Authorization of services.

5.6 **Appointment Standards:** The Contractor shall comply with appointment standards that are no longer than the following (42 CFR 438.206(c)(1)(i)):

5.6.1 Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

5.6.2 Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

5.6.3 Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.

5.6.4 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

5.7 **Integrated Provider Network Database (IPND):** The Contractor shall report their complete provider network, to include all current contracted providers, monthly to DSHS through the designated data management contact in accord with the Provider Network Reporting Requirements published by DSHS (see Attachment A for website link).

5.8 **Provider Network - Distance Standards:**

5.8.1 The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit A, Premiums and Service Areas.

5.8.1.1 PCP

Urban: 2 within 10 miles for 90% of BH enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of BH enrollees in the Contractor's service area.

5.8.1.2 Obstetrics

Urban: 2 within 10 miles for 90% of BH enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of BH enrollees in the Contractor's service area.

5.8.1.3 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

Urban: 2 within 10 miles for 90% of BH enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of BH enrollees in the Contractor's service area.

5.8.1.4 Hospital

Urban/Rural: 1 within 25 miles for 90% of BH enrollees in the Contractor's service area.

5.8.1.5 Pharmacy

Urban: 1 within 10 miles for 90% of BH enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of BH enrollees in the Contractor's service area.

5.8.2 DSHS may, in its sole discretion, grant exceptions to the distance standards. DSHS' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as DSHS may require to support the request. If the closest provider of the type subject to the standards in this section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.

5.9 **Standards for Specialty and Primary Care Providers:** The Contractor shall establish and meet measurable standards for the number of both PCPs and high volume Specialty Care Providers. The Contractor shall analyze performance against standards at minimum, annually.

5.10 **Access to Specialty Care:**

5.10.1 The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network.

5.10.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

5.11 **Order of Acceptance:** The Contractor shall maintain adequate capacity to provide care to BH enrollees in the Service Areas as outlined in Exhibit A, Premiums and Service Areas.

No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 CFR 438.6(d)(1&3)).

5.12 **Provider Network Changes:**

5.12.1 The Contractor shall give HCA and DSHS a minimum of ninety (90) calendar days' prior written notice, in accord with Section 12.26, Notices, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and/or the number of enrollees the Contractor has agreed to serve in a service area.

5.12.2 The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 CFR 438.10(f)(5)). Enrollee notices shall have prior approval of HCA and DSHS. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

6. QUALITY OF CARE

6.1 Quality Assessment and Performance Improvement (QAPI) Program:

6.1.1 The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the services it furnishes to its enrollees that meets the provisions of 42 CFR 438.240.

6.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.

6.1.1.2 The QAPI program structure shall include the following elements:

6.1.1.2.1 A written description of the QAPI program including identification of designated physician and behavioral health practitioners. The QAPI program description shall include:

6.1.1.2.1.1 A listing of all quality-related committee(s);

6.1.1.2.1.2 Descriptions of committee responsibilities;

6.1.1.2.1.3 Contractor staff and practicing provider committee participant titles;

6.1.1.2.1.4 Meeting frequency; and

6.1.1.2.1.5 Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.

6.1.1.2.2 A Quality Improvement Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

6.1.1.2.2.1 Recommend policy decisions;

6.1.1.2.2.2 Analyze and evaluate the results of QI activities;

6.1.1.2.2.3 Institute actions; and

6.1.1.2.2.4 Ensure appropriate follow-up.

6.1.1.2.3 An annual work plan.

6.1.1.2.4 An annual evaluation of the QAPI program to include an evaluation of performance improvement projects, trending of performance measures and evaluation of the overall effectiveness of the QI program.

6.1.2 The Contractor shall make available the QAPI program description, and information on the Contractor's progress towards meeting its goals to providers and enrollees upon request.

6.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

6.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity;

6.1.3.2 Evaluation of the delegated organization prior to delegation;

6.1.3.3 An annual evaluation of the delegated entity;

6.1.3.4 Evaluation of regular delegated entity reports; and

6.1.3.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

6.1.4 The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. (42 CFR 438.240 (b)(4)).

6.2 Performance Improvement Projects:

6.2.1 The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct at least five (5) Performance Improvement Projects (PIPs) of which at least three (3) are clinical and at least two (2) are non-clinical as described in 42 CFR 438.240 and as specified in the CMS protocol (see Attachment A for website link).

6.2.2 The projects must be 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. Through implementation of performance improvement projects, the Contractor shall:

6.2.2.1 Measure performance using objective, quality indicators.

6.2.2.2 Implement system interventions to achieve improvement in quality.

6.2.2.3 Evaluate the effectiveness of the interventions.

6.2.2.4 Plan and initiate activities for increasing or sustaining improvement.

6.2.2.5 Report the status and results of each project to DSHS and HCA.

6.2.2.6 Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year (CFR 42 438.240).

6.2.3 Annually, the Contractor shall submit to DSHS three (3) clinical and two (2) non-clinical performance improvement projects which, in the judgment of the Contractor, best meet the requirements of a performance improvement project. Each project will be documented on a performance improvement project worksheet found in the Conducting Performance Improvement Projects (see Attachment A for website link).

6.2.4 If any of the Contractor's Health Plan Employer Data and Information Set (HEDIS®) rates on Well Child Visits in the first fifteen (15) months, six (6) or more well child visits measure), Well Child Visits in the third (3rd), fourth (4th), fifth (5th) and sixth (6th) years of life, or Adolescent Well Care Visits are below sixty percent (60%) in 2006 or 2007, the Contractor shall implement a clinical PIP designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 6.2.1.

6.2.5 If any of the Contractor's HEDIS® Combination 2, Childhood Immunization rates are below seventy percent (70%) in 2006 or below seventy-five percent (75%) in 2007, the Contractor shall implement a performance improvement project designed to increase the rates. The Contractor may, at their option, count the required project toward meeting the requirement for at least three (3) clinical PIPs in Section 6.2.1.

6.2.6 The Contractor shall continue the CAHPS® non-clinical performance improvement project(s) required in the 2004-2005 HCA Contract for Basic Health Plus and Maternity Benefits Program and communicated by DSHS to the Contractor in February 2005 unless directed otherwise in writing by DSHS.

6.2.7 In addition to the PIPs required under Sections 6.2.1 through 6.2.6. and upon request of DSHS, the Contractor shall participate in a yearly statewide performance measure reporting project, performance improvement project or research project designed by DSHS. The study shall be designed to maximize resources and reduce cost to contractors. The Contractor will receive copies of aggregate data and reports produced from these projects.

6.3 **Performance Measures using Health Employer Data & Information Set (HEDISâ):**

6.3.1 In accord with Section 12.26, Notices, the Contractor shall report to HCA and DSHS HEDISâ measures using the current HEDISâ Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by HCA or DSHS. For the 2006 and 2007 HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDISâ Technical Specifications, unless directed otherwise by DSHS.

6.3.2 No later than June 15 of each year, HEDISâ measures shall be submitted electronically to HCA and DSHS using the NCQA data submission tool (DST) or other NCQA-approved method.

6.3.3 The following HEDIS® measures shall be submitted to HCA and DSHS in 2006:

6.3.3.1 Childhood Immunization

6.3.3.2 Chlamydia Screening in Women

6.3.3.3 Prenatal and Postpartum Care

6.3.3.4 Well Child Visits in the First 15 Months of Life

6.3.3.5 Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.3.3.6 Adolescent Well Child Visits

6.3.3.7 Use of Appropriate Medications for People with Asthma

6.3.3.8 Children and Adolescents' Access to Primary Care Practitioners

6.3.3.9 Practitioner Turnover (for Primary Care Practitioners and OB/GYN and other Prenatal Care Practitioners only)

6.3.3.10 Inpatient Utilization-General Hospital/Acute Care

6.3.3.11 Ambulatory Care

6.3.3.12 Birth and Average Length of Stay, Newborns

6.3.4 The following HEDIS® measures shall be submitted to HCA and DSHS in 2007:

6.3.4.1 Childhood Immunization

6.3.4.2 Chlamydia Screening in Women

6.3.4.3 Prenatal and Postpartum Care

6.3.4.4 Well Child Visits in the First 15 Months of Life

6.3.4.5 Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

6.3.4.6 Adolescent Well Child Visits

6.3.4.7 Use of Appropriate Medications for People with Asthma

6.3.4.8 Comprehensive Diabetes Care

6.3.4.9 Children and Adolescents' Access to Primary Care Practitioners

6.3.4.10 Practitioner Turnover (for Primary Care Practitioners and OB/GYN and other Prenatal Care Practitioners only)

6.3.4.11 Inpatient Utilization-General Hospital/Acute Care

6.3.4.12 Ambulatory Care

6.3.4.13 Birth and Average Length of Stay, Newborns

6.3.5 The Contractor shall submit raw HEDIS® data for three measures: Childhood Immunization, Use of Appropriate Medication for People with Asthma, and Children and Adolescents' Access to Primary Care Practitioners, no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data to HCA and DSHS electronically, according to specifications communicated by DSHS to the Contractor no later than February of each year.

6.3.6 All measures shall be audited, by a designated certified HEDIS® Compliance Auditor a licensed organization in accord with methods described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures. DSHS will fund and the DSHS designated EQRO will conduct the audit.

6.3.7 The Contractor shall cooperate with DSHS' designated EQRO to validate the Contractor's Health Employer Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

6.3.7.1 If the Contractor does not have NCQA accreditation for BH managed care from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

6.3.7.2 If the Contractor has NCQA accreditation for BH managed care or is seeking accreditation with a scheduled NCQA visit in 2006 or 2007, the Contractor shall receive a full audit.

6.3.7.3 Data collected and the methods employed for HEDISâ validation may be supplemented by indicators and/or processes published in the Centers for Medicare and Medicaid (CMS) Validating Performance Measures protocol identified by the DSHS designated EQRO.

6.3.8 The Contractor shall provide evidence of trending of measures to assess performance in quality and safety of clinical care and quality of non-clinical or service-related care.

6.3.9 The Contractor shall collect and maintain data on ethnicity, race and language markers as established by DSHS on all enrollees by January 1, 2007. The Contractor shall record and maintain enrollee self-identified data as established by the Contractor.

6.3.10 The Contractor shall rotate HEDIS® measures only with the advance written permission of DSHS. The Contractor may request permission to rotate measures by making a written request to the DSHS contact named in the Notices Section of this Contract, Section 12.26. Childhood Immunization and well-child measures shall not be rotated.

6.4 **Consumer Assessment of Health Plans Survey (CAHPS®):**

6.4.1 In 2006, A DSHS designated EQRO shall conduct the CAHPS® Children and Children with Chronic Conditions survey based upon 2006 HEDISâ Specifications for Survey Measures.

6.4.1.1 The Contractor shall create the sampling frame file.

6.4.1.1.1 The Contractor shall receive file specifications and instructions specifying the format and other required information for the sample files from DSHS, or the DSHS designated EQRO, by November 30, 2005.

6.4.1.1.2 The Contractor shall submit the eligible sample frames to the DSHS designated EQRO by January 16, 2006.

6.4.1.1.3 The Contractor's eligible sample frame file(s) will be certified by the DSHS EQRO, a Certified HEDISâ Auditor.

6.4.1.1.4 The Contractor shall receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 30, 2006.

6.4.1.2 The Contractor will be allowed up to eight (8) Contractor—determined supplemental questions and DSHS will also be allowed up to eight (8) supplemental questions. The Contractor will be notified of DSHS selected eight (8) supplemental questions.

6.4.1.2.1 The Contractor shall submit the questions to DSHS for written approval for the amount, content, and survey placement prior to December 15, 2005.

6.4.1.2.2 The Contractor shall receive a copy of the approved DSHS questionnaire for informational purposes by January 30, 2006. DSHS EQRO shall determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Children and Children with Chronic Conditions questionnaire, plus approved supplemental and/or custom questions as determined by DSHS.

6.4.1.3 The Contractor shall provide National CAHPS® Benchmarking Database (NCBD) submission information as determined by DSHS.

6.4.1.3.1 The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2006. The DSHS designated EQRO shall submit the data to the NCBD.

6.4.2 In 2007, the Contractor shall conduct the CAHPS® of adult Medicaid members enrolled in BH.

6.4.2.1 The Contractor shall contract with an NCQA certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the DSHS designated EQRO:

6.4.2.1.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name and CAHPS® primary vendor contact by January 5, 2007.

6.4.2.1.2 Timeline for implementation of vendor tasks by February 15, 2007.

6.4.2.2 The Contractor shall ensure the survey sample frame consists of all non-Medicare and non-commercial adult plan members (not just subscribers) 18 (eighteen) years and older with Washington State addresses. The Contractor shall submit the survey sample frame to DSHS by January 12, 2007. In administering the CAHPS® the Contractor shall:

6.4.2.2.1 Be allowed up to eight (8) Contractor-determined supplemental questions.

6.4.2.2.2 Allow DSHS up to eight (8) supplemental questions.

6.4.2.2.3 Be notified of DSHS' selected eight (8) supplemental questions on or before November 1, 2005.

6.4.2.2.4 Submit their questions to DSHS for written approval prior to December 15, 2006.

6.4.2.2.5 Submit the eligible sample frame file(s) for certification by the DSHS designated EQRO, a Certified HEDISâ Auditor by January 12, 2007.

6.4.2.2.6 Receive written notice of the sample frame file(s) compliance audit certification from the DSHS designated EQRO by January 31, 2007.

6.4.2.2.7 Receive the approved DSHS questionnaire by January 31, 2007. DSHS EQRO shall determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid adult questionnaire (currently

3.0H), plus

approved supplemental and/or custom questions as determined by DSHS.

6.4.2.2.8 Conduct the mixed methodology (mail and phone surveys) for CAHPS® survey administration.

6.4.2.2.9 Submit the final disposition report by June 10, 2007.

6.4.2.2.10 Submit a copy of the Washington State adult Medicaid response data set according to 2007 NCQA/CAHPS® standards to the DSHS designated EQRO by June 10, 2007.

6.4.2.3 The Contractor shall provide NCBD data submission information as determined by DSHS.

6.4.2.3.1 The Contractor shall submit the information to the DSHS designated EQRO by April 14, 2007.

6.4.2.3.2 The DSHS designated EQRO shall submit the data to the NCBD.

6.4.2.4 The Contractor is required to include performance guarantee language in their vendor subcontracts that require a vendor to achieve at least a thirty-five percent (35%) response rate.

6.4.3 If a Contractor cannot conduct the required annual CAHPS® surveys (Children, Children with Chronic Conditions, or Adult) because of limited total enrollment and/or sample size, the Contractor shall notify DSHS in writing whether they have a physician or physician group at substantial financial risk in accord with the physician incentive plan requirements under Section 7.9.

6.5 **External Quality Review:**

6.5.1 Validation Activities: The Contractor's quality program shall be examined using a series of required validation procedures. The examination shall be implemented and conducted by DSHS, its agent, or an EQRO.

6.5.2 The following required activities will be validated:

6.5.2.1 Performance improvement projects;

6.5.2.2 Performance measures; and

6.5.2.3 A monitoring review of standards established by DSHS and included in this Contract to comply with 42 CFR 438.204 (g) and a comprehensive review conducted within the previous three-year period (42 CFR 438.358(b)(1)(2)(3)).

6.5.3 The following optional activity will be validated annually:

6.5.3.1 Administration and/or validation of consumer or provider surveys of quality of care, i.e., the CAHPS® survey.

6.5.4 DSHS reserves the right to include additional optional activities described in 42 CFR 438.358 if additional funding becomes available and as mutually negotiated between DSHS and the Contractor.

6.5.5 The Contractor shall submit to annual DSHS TeaMonitor and EQRO monitoring reviews. The monitoring review process uses standard methods and data collection tools and methods found in the CMS External Quality Review Protocols and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs.

6.5.5.1 The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by HCA, DSHS or its External Quality Review Organization (EQRO) contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to enrollees.

6.5.5.2 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report (EQRR). The EQRR is a detailed technical report that describes the manner in which the data from all activities described in Sections 6.5.1 through 6.5.3 and conducted in accord with CFR 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the MCO.

6.5.5.3 DSHS will provide a copy of the EQRR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, enrollees and potential enrollees of the Contractor, recipient advocacy groups, and members of the general public. DSHS must make this information available in alternative formats for persons with sensory impairments, when requested.

6.5.5.4 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA and DSHS. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state

representative shall be allowed to share information with HCA, DSHS and Department of Health (DOH), as needed to reduce duplicated work for both the Contractor and the state.

6.6 **Enrollee Mortality:** The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of

death, and cause(s) of death. This information shall be available to HCA or DSHS upon request. The Contractor shall assist HCA or DSHS in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.7 **Practice Guidelines:** The Contractor shall adopt practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 CFR 438.236):

6.7.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

6.7.2 Consider the needs of enrollees and support client and family involvement in care plans;

6.7.3 Are adopted in consultation with contracting health care professionals;

6.7.4 Are reviewed and updated at least every two years and as appropriate;

6.7.5 Are disseminated to all affected providers and, upon request, to HCA, DSHS, enrollees and potential enrollees; and

6.7.6 Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply.

6.8 **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to DSHS for review and approval by January 31 of each year of this Contract. The formulary shall be submitted to:

Siri Childs, Pharm D, Pharmacy Policy Manager (or her successor)
Department of Social and Health Services
Division of Medical Management
P.O. Box 45506
Olympia, WA 98504-5506
E-mail: childsa@dshs.wa.gov

7. SUBCONTRACTS

7.1 **Contractor Remains Legally Responsible**: Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract. However, no subcontract shall terminate the Contractor's legal responsibility to HCA or DSHS for any work performed under this Contract (42 CFR 434.6 (c)).

7.2 **Solvency Requirements for Subcontractors**: For any subcontractor at financial risk, as described in Section 7.9.3 Substantial Financial Risk, or Section 1.45,

Risk, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

7.3 **Provider Nondiscrimination**:

7.3.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.

7.3.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

7.3.3 The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).

7.3.4 Consistent with the Contractor's responsibilities to the enrollees, this Section may not be construed to require the Contractor to Contract with providers beyond the number necessary to meet the needs of its enrollees; preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

7.4 **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

7.4.1 Identification of the parties of the subcontract and their legal basis for operation in the State of Washington.

7.4.2 Procedures and specific criteria for terminating the subcontract.

7.4.3 Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.

7.4.4 Reimbursement rates and procedures for services provided under the subcontract.

7.4.5 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

7.4.6 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA, DSHS or DHHS for audit purposes, and immediate access for Medicaid fraud investigators.

7.4.7 The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all DSHS required data to enable the Contractor to meet the reporting requirements in the Encounter Data Transaction Guide published by DSHS.

7.4.8 The requirement to comply with the Contractor's DSHS approved fraud and abuse policies and procedures.

7.4.9 No assignment of the subcontract shall take effect without the HCA's written agreement.

7.4.10 The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this Contract, including the applicable requirements of 42 CFR 438.6(1).

7.4.11 Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract.

7.4.12 The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):

7.4.12.1 The toll-free numbers to file oral grievances and appeals.

7.4.12.2 The availability of assistance in filing a grievance or appeal.

7.4.12.3 The enrollee's right to request continuation of benefits during an appeal or hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits.

7.4.12.4 The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

7.4.12.5 The enrollee's right to a hearing, how to obtain a hearing, and representation rules at a hearing.

7.5 **Health Care Provider Subcontracts**, including those for facilities and pharmacy benefit management, shall also contain the following provisions:

7.5.1 A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

7.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with QI activities.

7.5.3 A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.

7.5.3.1 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

7.5.3.1.1 Assigned responsibilities;

7.5.3.1.2 Delegated activities;

7.5.3.1.3 A mechanism for evaluation; and

7.5.3.1.4 Corrective action policy and procedure.

7.5.4 Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

7.5.5 The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from HCA, DSHS or any enrollee for covered services performed under the subcontract.

7.5.6 The subcontractor agrees to hold harmless HCA and its employees and DSHS and its employees, and all enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless HCA and its employees and DSHS and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA and its employees and DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

7.5.7 If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this Contract.

7.5.8 A ninety (90) day termination notice provision.

7.5.9 A specific termination provision for termination with short notice when a provider is excluded from participation in the Medicaid program.

7.5.10 The subcontractor agrees to comply with the appointment wait time standards of this Contract. The subcontract must provide for regular

monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 CFR 438.206(c)(1)).

7.5.11 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 CFR 438.230(b)).

7.6 **Health Care Provider Subcontracts Delegating Administrative Functions:** Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:

7.6.1 For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

7.6.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract, including but not limited to utilization/medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

7.6.3 How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

7.6.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate.

7.6.5 Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

7.7 **Excluded Providers:**

7.7.1 Pursuant to Section 1128 of the Social Security Act, the Contractor may not subcontract with an individual practitioner or provider, or an entity with an officer, director, agent, or manager, or an individual who owns or has a controlling interest in the entity, who has been: convicted of crimes as specified in Section 1128 of the Social Security Act, excluded from participation in the Medicare and Medicaid program, assessed a civil penalty under the provisions of Section 1128, has a contractual relationship with an entity convicted of a crime specified in Section 1128, or is a person described in Section 12.12 of this Contract, Exclusions and Debarment. The Contractor shall terminate subcontracts of excluded providers immediately with the Contractor becomes aware of such exclusion or when the Contractor receives notice from HCA or DSHS, whichever is earlier.

7.7.2 In addition, if DSHS terminates a subcontractor from participation any DSHS program, the Contractor shall exclude the subcontractor from participation in BH. The Contractor shall terminate subcontracts of excluded providers immediately when the Contractor becomes aware of such exclusion or when the Contractor receives notice from HCA or DSHS, whichever is earlier (WAC 388-502-0030).

7.7.3 If the Contractor terminates a subcontractor for cause, the Contractor shall notify HCA and DSHS, within thirty (30) calendar days, in writing, as provided in the Notices Section of this Contract, Section 12.26, and explain the circumstances regarding the termination.

7.8 **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this Contract, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. DSHS will provide a current list of bonded home health agencies upon request to the Contractor.

7.9 **Physician Incentive Plans:** Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section in accord with federal regulations (42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210).

7.9.1 Prohibited Payments: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

7.9.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by HCA and DSHS. The Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of all its subcontractors in any tier, to HCA and DSHS annually upon request:

7.9.2.1 Whether the incentive plan includes referral services.

7.9.2.2 If the incentive plan includes referral services:

7.9.2.2.1 The type of incentive plan (e.g. withhold, bonus, capitation).

7.9.2.2.2 For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

7.9.2.2.3 Proof that stop-loss protection meets the requirements of Section 7.9.4.1, including the amount and type of stop-loss protection.

7.9.2.2.4 The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military and non-Medicaid Basic Health members.

7.9.3 Substantial Financial Risk: A physician, or physician group as defined herein, is at substantial financial risk when more than twenty-five percent (25%) of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 enrollees, arrangements that cause substantial financial risk include, but are not limited to, the following:

7.9.3.1 Withholds greater than twenty-five percent (25%) of total potential payments.

7.9.3.2 Withholds less than twenty-five percent (25%) of total potential payments but the physician or physician group is potentially liable for more than twenty-five percent (25%) of total potential payments.

7.9.3.3 Bonuses greater than thirty-three percent (33%) of total potential payments, less the bonus.

7.9.3.4 Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of total potential payments.

7.9.3.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than twenty-five percent (25%) of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

7.9.4 Requirements if a Physician or Physician Group is at Substantial Financial Risk: If the Contractor, or any subcontractor (e.g. IPA, PHO), places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

7.9.4.1 If aggregate stop-loss protection is provided, it must cover ninety percent (90%) of the costs of referral services that exceed twenty-five percent (25%) of maximum potential payments under the subcontract.

7.9.4.2 If stop-loss protection is based on a per-member limit, it must cover ninety percent (90%) of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is

provided separately for professional and institutional services or is combined for the two.

7.9.4.2.1 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

7.9.4.2.2 1,001 - - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

7.9.4.2.3 5,001 - - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

7.9.4.2.4 8,001 - - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

7.9.4.2.5 10,001 - - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

7.9.4.2.6 25,001 members or more, there is no risk threshold.

7.9.4.3 For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. DSHS shall require such surveys annually. DSHS may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement and waive the requirement for the Contractor to conduct such surveys. DSHS shall notify the Contractor in writing if the requirement is waived. If DSHS does not waive the requirement, the Contractor shall provide the survey results to HCA and DSHS annually upon request. The surveys shall:

7.9.4.3.1 Include current enrollees, and enrollees who have disenrolled within 12 months of the survey for reasons other than loss of Medicaid eligibility or moving outside the Contractor's service area.

7.9.4.3.2 Be conducted according to commonly accepted principles of survey design and statistical analysis.

7.9.4.3.3 Address enrollees satisfaction with the physician or physician groups:

7.9.4.3.3.1 Quality of services provided.

7.9.4.3.3.2 Degree of access to services.

7.9.5 Sanctions and Penalties: DSHS or CMS may impose intermediate sanctions, as described in Section 12.31, Sanctions, of this Contract, for failure to comply with the rules in this Section.

7.10 **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally-qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

7.11 **Provider Education:** The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction with the training process.

The Contractor shall maintain a system for keeping participating practitioners and providers informed about:

7.11.1 Covered services for enrollees served under this Contract;

7.11.2 Coordination of care requirements;

7.11.3 HCA and DSHS policies as related to this Contract;

7.11.4 Interpretation of data from the quality improvement program; and

7.11.5 Practice guidelines (see Section 6.7).

7.12 **Claims Payment Standards:** The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) of receipt and ninety-nine percent (99%) of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

7.12.1 A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

7.12.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

7.12.3 The date of receipt is the date the Contractor receives the claim from the provider**.**

7.12.4 The date of payment is the date of the check or other form of payment.

7.13 **FQHC/RHC Report:** The Contractor shall provide DSHS with information related to subcontracted federally-qualified health centers (FQHC) and rural health clinics (RHC), as required by the DSHS Healthy Options Licensed Health Carrier Billing Instructions, published by DSHS (see Attachment A for website link).

7.14 **Provider Credentialing:** The Contractor must have written policies and procedures for credentialing and recredentialing providers who have signed contracts or participation agreements with the Contractor.

7.14.1 The Contractor's medical director or other designated physician's shall have direct responsibility and participation in the credentialing process.

7.14.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

7.14.3 The Contractor's written Credentialing policies and procedures must specify at a minimum:

7.14.3.1 Type of providers that are credentialed and recredentialed;

7.14.3.2 Verification sources used to make credentialing decisions, including any evidence of provider sanctions; and

7.14.3.3 Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in Section 7.7, Excluded Providers.

7.14.4 The criteria used by the Contractor to credential and recredential providers shall include:

7.14.4.1 Evidence of a current valid license to practice;

7.14.4.2 A valid DEA or CDS certificate if applicable;

7.14.4.3 Evidence of appropriate education and training;

7.14.4.4 Board certification if applicable;

7.14.4.5 An Evaluation of work history; and

7.14.4.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider.

7.14.5 The Contractor's process for making credentialing determinations, to include a signed, dated attestation statement from the provider that addresses:

7.14.5.1 The lack of present illegal drug use;

7.14.5.2 A history of loss of license and felony convictions;

7.14.5.3 A history of loss or limitation of privileges or disciplinary activity;

7.14.5.4 Current malpractice coverage; and

7.14.5.5 Accuracy and completeness of the application.

7.14.6 The Contractor's process for delegation of credentialing or recredentialing.

7.14.7 The Contractor's provider selection policies and procedures that are consistent with 42 CFR 438.12, and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

7.14.8 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials, including:

7.14.8.1 Communication of the provider's right to review materials;

7.14.8.2 Correct incorrect or erroneous information;

7.14.8.3 Be informed of their credentialing status; and

7.14.8.4 The ability to appeal an adverse determination by the Contractor.

7.14.9 The Contractor's process for notifying providers within sixty (60) days of the credentialing committee's decision.

7.14.10 The Contractor a process to ensure confidentiality.

7.14.11 The Contractor's process to ensure listings in provider directories for enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

7.14.12 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.

7.14.13 The Contractor's process to ensure that offices of all primary care providers, obstetricians/gynecologists and high volume providers meet office site standards established by the Contractor.

7.14.14 A system for monitoring sanctions or limitations on licensure, complaints and quality issues or information from identified adverse events and

provides evidence of action, as appropriate based on defined methods or criteria.

8. **ENROLLEE RIGHTS AND PROTECTIONS:**

8.1 **General Requirements**: The Contractor shall have written policies and procedures regarding all enrollee rights (42 CFR 438.100(a)(1)).

8.1.1 The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2)).

8.1.2 The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):

8.1.2.1 To be treated with respect and with consideration for their dignity and privacy.

8.1.2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand.

8.1.2.3 To participate in decisions regarding their health care, including the right to refuse treatment.

8.1.2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

8.1.2.5 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164.

8.1.2.6 Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 CFR 438.100(c)).

8.2 **Cultural Considerations:** The Contractor shall participate in and cooperate with DSHS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).

8.3 **Advance Directives:**

8.3.1 The Contractor shall maintain written policies and procedures for advance directives that meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I. The Contractor's advance directive policies and procedure shall be

disseminated to all affected providers, enrollees, DSHS, and, upon request, potential enrollees.

8.3.2 The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

8.3.3 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

8.3.4 Identify the state legal authority permitting such objection.

8.3.5 Describe the range of medical conditions or procedures affected by the conscience objection.

8.3.6 If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

8.3.7 The Contractor's policies and procedures must require, and the Contractor must ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive.

8.3.8 The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive.

8.3.9 The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives.

8.3.10 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.

8.3.11 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor.

The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts.

8.3.12 The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

8.3.13 The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements.

8.4 **Enrollee Choice of PCP:**

8.4.1 The Contractor must implement procedures to ensure each enrollee has a source of primary care appropriate to their needs.

8.4.2 The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP.

8.4.3 In the case of newborns, the parent shall choose the newborn's PCP.

8.4.4 If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) working days after coverage begins.

8.4.5 The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and WAC 284-43-251(1)).

8.5 **Direct Access for Enrollees with Special Health Care Needs:** The Contractor shall allow children with special health care needs who utilize a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this Contract demonstrates a need for a course

of treatment or regular monitoring by such specialist (42 CFR 438.208 and 438.6(m)).

8.6 **Prohibition on Enrollee Charges for Covered Services:** Under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for covered services (SSA 1932(b)(6), SSA 1128B(d)(1)) and WAC 388-502-0160).

8.7 **Provider/Enrollee Communication:** The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following (42 CFR 438.102(a)(1)):

8.7.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

8.7.2 Any information the enrollee needs in order to decide among all relevant treatment options.

8.7.3 The risks, benefits, and consequences of treatment or non-treatment.

8.7.4 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.

8.8 **Enrollee Self-Determination:** The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

9. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

9.1 **Utilization Management Program:**

9.1.1 The Contractor shall have and maintain a Utilization Management Program (UMP) for the services it furnishes its enrollees.

9.1.2 The Contractor shall define its UMP structure and assign responsibility to appropriate individuals.

9.1.3 Upon request by HCA or DSHS the Contractor shall provide the requesting party with a written description of the UMP that includes identification of designated physician and behavioral health practitioner's and evidence of the physician and behavioral health practitioner's involvement in program

development and implementation The UMP program description shall include:

9.1.3.1 A written description of all UM-related committee(s);

9.1.3.2 Descriptions of committee responsibilities;

9.1.3.3 Contractor staff and practicing provider committee participant title(s);

9.1.3.4 Meeting frequency;

9.1.3.5 Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.

9.1.4 UMP behavioral health and non-behavioral health policies and procedures at minimum, shall include the following content:

9.1.4.1 Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria.

9.1.4.2 Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same.

9.1.4.3 Mechanisms for assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

9.1.4.4 Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current non-restricted license.

9.1.4.5 Mechanisms to verify that claimed services were actually provided.

9.1.4.6 Mechanisms to detect both underutilization and over utilization of services and produce a yearly report which identifies and reports findings on utilization measures and includes completed or planned interventions to address under or over-utilization patterns of care.

9.1.4.6.1 Specify the type of personnel responsible for each level of UM decision-making.

9.1.4.6.2 A physician or behavioral health practitioner or pharmacist as appropriate reviews any behavioral health denial of care based on medical necessity.

9.1.4.6.3 Use of board certified consultants to assist in making medical necessity determinations.

9.1.4.6.4 Appeals of adverse determinations evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person’s condition or disease (PBOR, WAC 284-43-620(4)).

9.1.4.7 Documentation of timelines for appeals in accord with Sections 10.3.9.1 and 10.3.9.2.

9.1.5 Annually evaluate and update the UM program.

9.1.6 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

9.1.7 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the Contractor’s determination with respect to coverage or payment for health care service (PBOR, WAC 284-43-210(6)).

9.2 **Authorization of Services:** The Contractor shall have in place policies and procedures for the authorization of services that comply with 42 CFR 438.210, WAC 388-538 and the provisions of this Contract and require subcontractors with delegated authority for authorization to comply with such policies and procedures.

9.2.1 The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

9.2.2 The Contractor shall consult with the requesting provider when appropriate.

9.2.3 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.

9.2.4 The Contractor shall notify the requesting provider, and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet

the following requirements, except that the notice to the provider need not be in writing (42 CFR 438.404):

9.2.4.1 The notice to the enrollee shall be in writing and shall meet the requirements of Section 3.2, Information Requirements for Enrollees and Potential Enrollees, of this Contract to ensure ease of understanding.

9.2.4.2 The notice shall explain the following:

9.2.4.2.1 The action the Contractor has taken or intends to take.

9.2.4.2.2 The reasons for the action, in easily understood language.

9.2.4.2.3 The enrollee's right to file an appeal.

9.2.4.2.4 The procedures for exercising the enrollee's rights.

9.2.4.2.5 The circumstances under which expedited resolution is available and how to request it.

9.2.4.2.6 The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

9.2.5 The Contractor shall provide for the following timeframes for authorization decisions and notices:

9.2.5.1 For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

9.2.5.2 For termination, suspension, or reduction of previously authorized services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

9.2.5.2.1 For standard authorization, determinations are to be made within two (2) business days of the receipt of necessary information, but may not exceed fourteen (14) calendar days following receipt of the request for services.

9.2.5.2.2 Beyond the fourteen (14) calendar day period, a possible extension of up to fourteen (14) additional calendar days (equal to a total of twenty-eight (28) calendar days) is allowed under the following circumstances (42 CFR 438.210):

9.2.5.2.2.1 The enrollee, or the provider, requests extension; or

9.2.5.2.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

9.2.5.2.2.3 If the Contractor extends that timeframe, it shall:

9.2.5.2.2.3.1 Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

9.2.5.2.2.3.2 Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

9.2.5.2.3 For standard authorization decisions, notification of the decision shall be made to the attending physician, ordering provider, facility and enrollee within two (2) calendar days (PBOR, WAC 284-43-410).

9.2.5.3 For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. The Contractor may extend the three (3) working days by up to fourteen (14) calendar days under the following circumstances:

9.2.5.3.1 The enrollee requests the extension; or

9.2.5.3.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10. GRIEVANCE SYSTEM

10.1 **General Requirements**: The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F and WACs 388-538 and 284-43, insofar as it is not in conflict with 42 CFR 438 Subpart F. The grievance system shall include a grievance process, an appeal process, and access to the hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

10.1.1 The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. DSHS must approve, in writing, all grievance system policies and

procedures and related notices to enrollees regarding the grievance system. DSHS must also approve in writing any changes to policies and procedures.

10.1.2 The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (WAC 284-43-615(2)(e)).

10.1.3 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days.

10.1.4 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making.

10.1.5 Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

10.1.5.1 If the enrollee is appealing an action concerning medical necessity.

10.1.5.2 If an enrollee grievance concerns a denial of expedited resolution of an appeal.

10.1.5.3 If the grievance or appeal involves any clinical issues.

10.2 **Grievance Process**: The following requirements are specific to the grievance process:

10.2.1 Only an enrollee may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee.

10.2.2 The Contractor shall accept grievances forwarded by HCA or DSHS.

10.2.3 The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615).

10.2.4 The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615).

10.2.5 The Contractor shall investigate and resolve all grievances (WAC 284-43-615).

10.2.6 The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the enrollees health condition requires, but no later than ninety (90) calendar days from receipt of the grievance.

10.2.7 The Contractor may notify enrollees of the disposition of grievances. The notification may be made orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

10.2.8 Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

10.3 **Appeal Process**: The following requirements are specific to the appeal process:

10.3.1 An enrollee, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action.

10.3.2 If HCA receives a request to appeal an action of the Contractor, HCA will cooperate with DSHS to forward relevant information to the Contractor and the Contractor will contact the enrollee.

10.3.3 For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal.

10.3.4 For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 CFR 438.408).

10.3.5 Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution.

10.3.6 The appeal process shall provide the enrollee a 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 expedited resolution.

10.3.7 The appeal process shall provide the enrollee and the enrollee's representative 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 appeal process.

10.3.8 The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

10.3.9 The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes:

10.3.9.1 For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) days after receipt of the appeal, unless the Contractor notifies the enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty (30) days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.

10.3.9.2 For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.

10.3.10 The notice of the resolution of the appeal shall:

10.3.10.1 Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

10.3.10.2 Include the reasons for the determination in easily understood language and the date completed.

10.3.10.3 A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision-making criteria.

10.3.10.4 For appeals not resolved wholly in favor of the enrollee:

10.3.10.4.1 Include information on the enrollee's right to request a hearing and how to do so.

10.3.10.4.2 Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

10.3.10.4.3 Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

10.4 **Expedited Appeal Process**:

10.4.1 The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's

behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

10.4.2 The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.

10.4.3 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

10.4.4 If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

10.4.5 The enrollee has a right to file a grievance regarding the Contractors denial of a request for expedited resolution. The Contractor must inform the enrollee of their right to file a grievance in the notice of denial.

10.5 **Hearings:**

10.5.1 A provider may not request a hearing on behalf of an enrollee.

10.5.2 If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a hearing within the following time frames (see WAC 388-538-112 for the hearing process for enrollees):

10.5.2.1 For hearings regarding a standard service, within ninety (90) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal.

10.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the

appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply.

10.5.3 If the enrollee requests a hearing, the Contractor shall provide to DSHS upon request and within three (3) working days, all Contractor-held documentation related to the appeal, including but not limited to, any

transcript(s), records, or written decision(s) from participating providers or delegated entities.

10.5.4 The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.

10.5.5 The Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals, when medical necessity is an issue.

10.5.6 The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with DSHS.

10.5.7 DSHS will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision. Implementation of such a hearing decision shall not be the basis for disenrollment of the enrollee by the Contractor.

10.5.8 If the hearing decision is not within the purview of this Contract, then DSHS will be responsible for the implementation of the hearing decision.

10.6 **Independent Review**: After exhausting both the Contractor's appeal process and the hearing process an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-43-630.

10.7 **Board of Appeals:** An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the DSHS Board of Appeals in accord with WAC ###-##-#### through ###-##-####. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.

10.8 **Continuation of Services**:

10.8.1 The Contractor shall continue the enrollee's services if all of the following apply:

10.8.1.1 An appeal, hearing or independent review is requested on or before the later of the following:

10.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

10.8.1.1.2 The intended effective date of the Contractor's proposed action.

10.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

10.8.1.3 The services were ordered by an authorized provider.

10.8.1.4 The original period covered by the original authorization has not expired.

10.8.1.5 The enrollee requests an extension of services.

10.8.2 If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing, independent review or DSHS Board of Appeals is pending, the services shall be continued until one of the following occurs:

10.8.2.1 The enrollee withdraws the appeal, hearing or independent review request.

10.8.2.2 Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days.

10.8.2.3 Ten (10) calendar days pass after DSHS mails the notice of resolution of the hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.

10.8.2.4 Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollees has not requested a DSHS Board of Appeals (with continuation of services until the DSHS Board of Appeals decision is reached) within ten (10) calendar days.

10.8.2.5 The time period or service limits of a previously authorized service has been met.

10.8.3 If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

10.9 **Effect of Reversed Resolutions of Appeals and Hearings**:

10.9.1 If the Contractor, DSHS Office of Administrative Hearings (OAH), independent review organization (IRO) or DSHS Board of Appeals reverses a decision to deny, limit, or delay services that were not provided 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.

10.9.2 If the Contractor, OAH, IRO or DSHS Board of Appeals 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.

10.10 **Actions, Grievances, Appeals and Independent Reviews:** The Contractor shall maintain records of all actions, grievances, appeals and independent reviews of adverse appeal decisions by an independent review organization.

10.10.1 The records shall include actions, grievances and appeals handled by delegated entities.

10.10.2 The Contractor shall provide a report of complete actions, grievances, appeals and independent reviews to DSHS biannually for the prior six months.

10.10.2.1 The report for the six months ending March 31 is due no later than June 1.

10.10.2.2 The report for the six months ending September 30 is due no later than November 1.

10.10.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities.

10.10.4 Delegated actions, grievances and appeals are to be integrated into the Contractor's report.

10.10.5 Data shall be reported in the DSHS and Contractor agreed upon format.

10.10.6 The report medium shall be specified by DSHS.

10.10.7 Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the enrollee may be liable for payment.

10.10.8 The Contractor shall provide information to HCA or DSHS regarding denial of payment to providers upon request.

10.10.9 Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action.

10.10.10 The records shall include, at a minimum:

10.10.10.1 Plan Name

10.10.10.2 Name of the delegated entity, if any

10.10.10.3 Quarter of occurrence

10.10.10.4 Name of Program: BH

10.10.10.5 Enrollee Identifier - Patient Identification Code (PIC)

10.10.10.5.1 Enrollee Last Name

10.10.10.5.2 Enrollee First Name

10.10.10.5.3 Enrollee Middle Initial

10.10.10.5.4 Enrollee Birthday

10.10.10.6 Provider Last Name

10.10.10.7 Provider First Name

10.10.10.8 Provider Middle Initial

10.10.10.9 Provider Category (Optional)

10.10.10.10 Provider Category Code (Optional)

10.10.10.11 Type/Level:

10.10.10.11.1 Type 1 Grievance

10.10.10.11.2 Type 3 Action

10.10.10.11.3 Type 4 Appeal - First Level

10.10.10.11.4 Type 5 Appeal - Second Level

10.10.10.11.5 Type 6 IRO

10.10.10.12 Expedited: Yes or No

10.10.10.13 Grievance, Appeal or Requested Service Denied Category

10.10.10.14 Grievance or Requested Service Denied Category Code

10.10.10.15 Grievance or Action Reason Type

10.10.10.16 Grievance or Action Reason Type Code

10.10.10.17 Resolution of Grievance, Appeal or IRO

10.10.10.18 Date Received

10.10.10.19 Date of Resolution

10.10.10.20 Resolution Code

10.10.10.21 Date written notification of Action or Grievance, Appeal or IRO outcome sent to enrollee and provider

11. BENEFITS

11.1 Scope of Services:

11.1.1 The Contractor is responsible for covering medically necessary services relating to:

11.1.1.1 The prevention, diagnosis, and treatment of health impairments.

11.1.1.2 The achievement of age-appropriate growth and development.

11.1.1.3 The attainment, maintenance, or regaining of functional capacity.

11.1.2 If a specific procedure or element of a covered service is covered by DSHS under its fee-for-service program, as described in DSHS' billing instructions (see Attachment A for website link), the Contractor shall cover the service subject to the specific exclusions and limitations as described in this Contract.

11.1.3 Except as otherwise specifically provided in this Contract, the Contractor shall provide covered services in the amount, duration and scope described in the Medicaid State Plan.

11.1.4 The amount and duration of covered services that are medically necessary depends on the enrollee's condition.

11.1.5 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition.

11.1.6 Except as specifically provided in Section 9.2, Authorization of Services, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that

utilization control measures do not deny medically necessary covered services to enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program.

11.1.7 For specific covered services, the requirements of this Section shall also not be construed as requiring the Contractor to cover the specific items covered by DSHS under its fee-for-service program, but shall rather be construed to require the Contractor to cover the same scope of services.

11.1.8 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of services covered under this Contract.

11.1.9 The Contractor may limit coverage of services to participating providers except as specifically provided in Section 5, Access; Section 11, Benefits, for emergency services; as necessary to provide medically necessary services as described in Section 11.1.11 Outside the Service Areas; and as necessary to coordinate benefits under the requirements of Section 11.15.1, Coordination of Benefits, when an enrollee has other medical coverage.

11.1.10 Within the Service Areas: Within the Contractor's service areas, as defined in Section 2.1, Service Areas, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this Contract.

11.1.11 Outside the Service Areas: For the enrollees still enrolled with the Contractor who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

11.1.11.1 Emergency and post-stabilization services.

11.1.11.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require pre-authorization for urgent care services as long as the wait times specified in Section 5.6, Appointment Standards, are not exceeded.

11.1.11.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require pre-authorization for such services as long as the wait times specified in Section 5.6, Appointment Standards, are not exceeded.

11.1.11.4 The Contractor's obligation for services outside the service area is limited to ninety (90) calendar days beginning with the first of the month following the month in which the enrollee leaves the service area or changes residence.

11.1.11.5 The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

11.2 **Medical Necessity Determination:** The Contractor shall determine which services are medically necessary, according to utilization management requirements and the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding appeals, hearings and independent review.

11.3 **Enrollee Self-Referral:**

11.3.1 Enrollees have the right to self-refer for certain services to local health departments and family planning clinics paid through separate arrangements with the State of Washington.

11.3.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

11.3.3 The enrollees also may choose to receive such services from the Contractor. The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

11.3.4 If the Contractor subcontracts with local health departments or family planning clinics as participating providers or refers enrollees to them to receive services, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

11.3.5 The services to which an enrollee may self-refer are:

11.3.5.1 Family planning services and sexually-transmitted disease screening and treatment services provided at family planning facilities, such as Planned Parenthood.

11.3.5.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening

and follow-up, and family planning services through the local health department.

11.4 **Women's Health Care Services:** The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractors network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

11.5 **Maternity Newborn Length of Stay:** The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

11.6 **Continuity of Care:** The Contract shall ensure the Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted (42 CFR 438.208).

11.6.1 For changes in the Contractor's provider network or service areas, the Contractor shall comply with the provisions of Sections 2.1.3.3 and 5.13.2.

11.6.2 If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

11.6.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

11.6.4 The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

11.6.4.1 The thirtieth (30^{th}) calendar day after enrollment with the Contractor.

11.6.4.2 The enrollee's prescription expires.

11.6.4.3 A participating provider examines the enrollee to evaluate the continued need for the prescription. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill the prescription.

11.7 **Coordination of Care:** The Contractor shall ensure that health care services are coordinated for enrollees as follows (42 CFR 438.208):

11.7.1 The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care.

11.7.2 The Contractor shall also provide or shall ensure PCPs provide ongoing coordination of community-based services required by enrollees, including but not limited to:

11.7.2.1 First Steps Maternity Services and Maternity Case Management;

11.7.2.2 Transportation services;

11.7.2.3 Regional Support Networks for mental health services;

11.7.2.4 Developmental Disability services, including the Infant Toddler Early Intervention Program (ITEIP);

11.7.2.5 Health Department services, including Title V services for children with special health care needs;

11.7.2.6 Home and Community Services for older and physically disabled individuals; and

11.7.2.7 Alcohol and Substance Abuse services.

11.7.3 The Contractor shall provide support services to assist PCPs in providing coordination if it is not provided directly by the Contractor.

11.7.4 The Contractor shall ensure that enrollee health information is shared between providers in a manner that facilitates coordination of care while protecting confidentiality and enrollee rights.

11.7.5 The Contractor shall identify or shall ensure that providers identify enrollees with special health care needs as defined in WAC 388-538-050. The Contractor's obligation for identification of enrollees with special health care needs is limited to identification in the course of any contact or health care visit initiated by the enrollee and any information available to the Contractor regarding an enrollee's special health care needs.

11.7.6 The Contractor shall ensure that PCPs, in consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs and enrollees with special health care needs as defined herein, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

11.7.6.1 Documentation regarding the assessment and treatment plan shall be in the enrollee's case file, including enrollee participation in the development of the treatment plan.

11.7.6.2 If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.

11.7.7 The Contractor must implement procedure to share with other MCOs and RSNs serving the enrollee the results of its identification and assessment of any children with special health care needs and enrollee with special health care needs so that those activities are not duplicated while protecting confidentiality and enrollee rights (42 CFR 438.208 (b)(3)).

11.8 **Second Opinions:**

11.8.1 The Contractor must authorize a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or authorize for the enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for a qualified health care professional, at no cost to the enrollee.

11.8.2 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider (42 CFR 438.206(b)(3)).

11.9 **Sterilizations and Hysterectomies:** The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

11.10 **Experimental and Investigational Services:**

11.10.1 If the Contractor excludes or limits benefits for any services for one or more medical conditions or illnesses because such services are deemed to be experimental or investigational, the Contractor shall develop and follow policies and procedures for such exclusions and limitations. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA or DSHS upon request (WACs 284-44-043, 284-46-507 and 284-96-015).

11.10.2 In making the determination, whether a service is experimental and investigational and, therefore, not a covered service, the Contractor shall consider the following:

11.10.2.1 Evidence in peer-reviewed, medical literature, as defined herein, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether

the benefits of the service or treatment are outweighed by the risks of death or serious complications.

11.10.2.2 Whether evidence indicates the service or treatment is likely to be as beneficial as existing conventional treatment alternatives.

11.10.2.3 Any relevant, specific aspects of the condition.

11.10.2.4 Whether the service or treatment is generally used for the condition in the State of Washington.

11.10.2.5 Whether the service or treatment is under continuing scientific testing and research.

11.10.2.6 Whether the service or treatment shows a demonstrable benefit for the condition.

11.10.2.7 Whether the service or treatment is safe and efficacious.

11.10.2.8 Whether the service or treatment will result in greater benefits for the condition than another generally available service.

11.10.2.9 If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

11.10.3 Criteria to determine whether a service is experimental or investigational shall be no more stringent for Medicaid enrollees than that applied to any other members.

11.10.4 A service or treatment that is not experimental for one enrollee with a particular medical condition cannot be determined to be experimental for another enrollee with the same medical condition and similar health status.

11.10.5 A service or treatment may not be determined to be experimental and investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of significant benefit to enrollees.

11.10.6 An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, including independent review, through the hearing process and independent review.

11.11 **Enrollee Hospitalized at Enrollment:**

11.11.1 If an enrollee is enrolled in BH on the day the enrollee was admitted to an acute care hospital, then the plan the enrollee is enrolled with on the date

of admission shall be responsible for payment of all inpatient facility and professional services provided from the date of admission until the date the enrollee is no longer confined to an acute care hospital.

11.11.2 Except as provided in Section 11.11.4, for newborns born while their mother is hospitalized, the party responsible for the payment for the mother's hospitalization shall be responsible for payment of all inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital.

11.11.3 For newborns who are disenrolled retroactive to the date of birth and whose premiums are recouped as provided herein, DSHS shall be responsible for payment of all inpatient facility and professional services provided to and associated with the newborn. The provisions of 11.11.1 or 11.11.2 shall apply for services provided to and associated with the mother.

11.11.4 If DSHS is responsible for payment of all inpatient facility and professional services provided to a mother, DSHS shall not pay the Contractor a Delivery Case Rate under the provisions of Section 4.2.

11.12 **Enrollee Hospitalized at Disenrollment:** If an enrollee is in an acute care hospital at the time of disenrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered inpatient facility and professional services from the date of admission to the date the enrollee is no longer confined to an acute care hospital.

11.13 **General Description of Covered Services:** This Section is a general description of services covered under this Contract and is not intended to be exhaustive.

11.13.1 Medical services provided to enrollees who have a diagnosis of alcohol and/or chemical dependency or mental health diagnosis are covered when those services are otherwise covered services.

11.13.2 Inpatient Services: Provided by acute care hospitals (licensed under RCW 70.41), or nursing facilities (licensed under RCW 18.51) when nursing facility services are not covered by DSHS' Aging and Disability Services Administration and the Contractor determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included.

11.13.3 Outpatient Hospital Services: Provided by acute care hospitals (licensed under RCW 70.41).

11.13.4 Emergency Services and Post-stabilization Services:

11.13.4.1 Emergency Services: Emergency services are defined herein.

11.13.4.1.1 The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 CFR 438.114.

11.13.4.1.2 The Contractor shall cover all emergency services provided by a licensed provider, acting with in their scope of practice, without regard to whether the provider is a participating or non-participating provider (42 CFR 438.11 (c)(1)(i)).

11.13.4.1.3 Emergency services shall be provided without requiring prior authorization.

11.13.4.1.4 What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 CFR 438.114 (d)(i)).

11.13.4.1.5 The Contractor shall cover treatment obtained under the following circumstances:

11.13.4.1.5.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

11.13.4.1.5.2 A participating provider or other Contractor representative instructs the enrollee to seek emergency services.

11.13.4.1.6 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor.

11.13.4.2 Post-stabilization Services: Post-stabilization services are defined herein.

11.13.4.2.1 The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c).

11.13.4.2.2 The Contractor shall cover all post-stabilization services provided by a licensed provider, acting with in their scope of practice, without regard to whether the provider is a participating or non-participating provider.

11.13.4.2.3 The Contractor shall cover post-stabilization services under the following circumstances:

11.13.4.2.3.1 The services are pre-approved by a participating provider or other Contractor representative.

11.13.4.2.3.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within 1 hour of a request to the Contractor for pre-approval of further post-stabilization care services.

11.13.4.2.3.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and:

11.13.4.2.3.3.1 The Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(d));

11.13.4.2.3.3.2 The Contractor cannot be contacted; or

11.13.4.2.3.3.3 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 care of the enrollee until a Contractor physician is reached or one of the criteria in Section 11.13.4.2.4 is met.

11.13.4.2.4 The Contractor's responsibility for post-stabilization services it has not pre-approved ends when:

11.13.4.2.4.1 A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

11.13.4.2.4.2 A participating provider assumes responsibility for the enrollee's care through transfer;

11.13.4.2.4.3 A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

11.13.4.2.4.4 The enrollee is discharged.

11.13.5 Ambulatory Surgery Center: Services provided at ambulatory surgery centers.

11.13.6 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room or home) setting by licensed professionals

including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses, and certified dietitians. Provider Services include, but are not limited to:

11.13.6.1 Medical examinations, including wellness exams for adults and EPSDT for children

11.13.6.2 Immunizations

11.13.6.3 Maternity care

11.13.6.4 Family planning services provided or referred by a participating provider or practitioner

11.13.6.5 Performing and/or reading diagnostic tests

11.13.6.6 Private duty nursing

11.13.6.7 Surgical services

11.13.6.8 Services to correct defects from birth, illness, or trauma, or for mastectomy reconstruction

11.13.6.9 Anesthesia

11.13.6.10 Administering pharmaceutical products

11.13.6.11 Fitting prosthetic and orthotic devices

11.13.6.12 Rehabilitation services

11.13.6.13 Enrollee health education

11.13.6.14 Nutritional counseling for specific conditions such as diabetes, high blood pressure, and anemia

11.13.7 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, and peripheral blood stem cell.

11.13.8 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

11.13.9 Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may

restrict non-emergent care to participating providers. Enrollees may self-refer to participating providers for these services.

11.13.10 Outpatient Mental Health:

11.13.10.1 Psychiatric and psychological testing, evaluation and diagnosis:

11.13.10.1.1 Once every twelve (12) months for adults twenty-one (21) and over.

11.13.10.1.2 Unlimited for children under age twenty-one (21) when identified in an EPSDT visit.

11.13.10.2 Unlimited medication management:

11.13.10.2.1 Provided by the PCP or by PCP referral.

11.13.10.2.2 Provided in conjunction with mental health treatment covered by the Contractor.

11.13.10.3 Twelve hours per calendar year for treatment for enrollees who do not meet the RSNs access standards for receiving treatment.

11.13.10.4 Transition to the RSN, as appropriate to the enrollee's condition to assure continuity of care.

11.13.10.5 The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

11.13.10.6 The DSHS Mental Health Division (MHD) and the Division of Program Support (DPS) shall each appoint a Mental Health Care Coordinator (MHCC). The MHCCs shall be empowered to decide all Contractor and RSN issues regarding outpatient mental health coverage that cannot be otherwise resolved between the Contractor and the RSN. The MHCCs will also undertake training and technical assistance activities that further coordination of care between DPS, MHD, Healthy Options contractors, and RSNs. The Contractor shall cooperate with the activities of the MHCCs.

11.13.11 Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a DSHS recognized neurodevelopmental center.

The Contractor may refer children to a DSHS recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met (see Attachment A for website link).

11.13.12 Pharmaceutical Products: Prescription drug products according to a DSHS approved formulary, which includes both legend and over-the-counter (OTC) products. The Contractor's formulary shall include all therapeutic classes in DSHS' fee-for-service drug file and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs. The Contractor shall provide participating pharmacies and participating providers with its formulary and information about how to request non-formulary drugs. The Contractor shall have policies and procedures for the administration of the pharmacy benefit including formulary exceptions. The Contractor shall approve or deny all requests for non-formulary drugs by the business day following the day of request. Covered drug products shall include:

11.13.12.1 Oral, enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas;

11.13.12.2 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies; including but not limited to Depo-Provera, Norplant, and OTC products;

11.13.12.3 Antigens and allergens; and

11.13.12.4 Therapeutic vitamins and iron prescribed for prenatal and postnatal care.

11.13.13 Home Health Services: Home health services through state-licensed agencies.

11.13.14 Durable Medical Equipment (DME) and Supplies: Including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees.

11.13.15 Oxygen and Respiratory Services: Oxygen, and respiratory therapy equipment and supplies.

11.13.16 Hospice Services: When the enrollee elects hospice care. Includes facility services.

11.13.17 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In

areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

11.13.18 Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

11.13.19 Ambulance Transportation: The Contractor shall cover ground and air ambulance transportation for emergency medical conditions, as defined herein, including, but not limited to, Basic and Advanced Life Support Services, and other required transportation costs, such as tolls and fares. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

11.13.19.1 When it is necessary to transport an enrollee between facilities to receive a covered services; and,

11.13.19.2 When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

11.13.20 Smoking Cessation Services: For pregnant women through sixty (60) calendar days post pregnancy.

11.13.21 Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health as of November 1, 2005. A list of the required newborn screenings can be viewed at the Department of Health website (see Attachment A for website link).

11.13.22 EPSDT:

11.13.22.1 The Contractor shall meet all requirements under the DSHS EPSDT program policy and billing instructions (see Attachment A for website link).

11.13.22.2 The following services are cover when referred as a result of an EPSDT exam.

11.13.22.2.1 Chiropractic services;

11.13.22.2.2 Nutritional counseling; and

11.13.22.2.3 Unlimited psychiatric and psychological testing evaluation and diagnosis.

11.14 **Exclusions:** The following services and supplies are excluded from coverage under this agreement. Unless otherwise required by this agreement, ancillary services resulting from excluded services are also excluded. Complications

resulting from an excluded service are also excluded for a period of one hundred and eighty (180) calendar days following the occurrence of the excluded service not counting the date of service, except for complication resulting from surgery for weight loss or reduction, which are excluded for a period of three hundred and sixty-five (365) calendar days following the occurrence of the excluded service not counting the date of service. Thereafter, complications resulting from an excluded service are a covered service when they would otherwise be a covered service under the provisions of this Contract.

11.14.1 Services Covered By DSHS Fee-For-Service Or Through Other Contracts:

11.14.1.1 School Medical Services for Special Students as described in the DSHS billing instructions for School Medical Services.

11.14.1.2 Eyeglass Frames, Lenses, and Fabrication Services covered under DSHS' selective contract for these services, and associated fitting and dispensing services.

11.14.1.3 Voluntary Termination of Pregnancy.

11.14.1.4 Transportation Services other than Ambulance: including but not limited to Taxi, cabulance, voluntary transportation, public transportation and common carriers.

11.14.1.5 Dental Care, Prostheses, Orthodontics and Oral Surgery, including physical exams required prior to hospital admissions for oral surgery and anesthesia for dental care.

11.14.1.6 Hearing Aid Devices, including fitting, follow-up care and repair.

11.14.1.7 First Steps Maternity Case Management and Maternity Support Services.

11.14.1.8 Sterilizations for enrollees under age 21, or those that do not meet other federal requirements (42 CFR 441 Subpart F) (see Attachment A for website link).

11.14.1.9 Health care services provided by a neurodevelopmental center recognized by DSHS.

11.14.1.10 Services provided by a health department or family planning clinic when a client self-refers for care.

11.14.1.11 Inpatient psychiatric professional services.

11.14.1.12 Emergency mental health services.

11.14.1.13 Pharmaceutical products prescribed by any provider related to services provided under a separate Contract with DSHS.

11.14.1.14 Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division.

11.14.1.15 Protease Inhibitors.

11.14.1.16 Services ordered as a result of an EPSDT exam that are not otherwise covered services.

11.14.1.17 Surgical procedures for weight loss or reduction, when approved by DSHS in accord with WAC 388-531-0200. The Contractor has no obligation to cover surgical procedures for weight loss or reduction.

11.14.1.18 Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. Genetic services beyond Prenatal Diagnosis Genetic Counseling are covered only for pregnant women as maternity care when medically necessary, see Section 11.13.6.3.

11.14.1.19 Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS in accord with WAC 388-531.

11.14.2 Services Covered By Other Divisions In The Department Of Social And Health Services:

11.14.2.1 Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA).

11.14.2.2 Community-based services (e.g., COPES and Personal Care Services) covered through the Aging and Disability Services Administration.

11.14.2.3 Nursing facilities covered through the Aging and Disability Services Administration.

11.14.2.4 Mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, Club House, respite care, Supported Employment and inpatient psychiatric services.

11.14.2.5 Health care services covered through the Division of Developmental Disabilities for institutionalized clients.

11.14.2.6 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit.

11.14.3 Services Not Covered by Either DSHS or the Contractor:

11.14.3.1 Medical examinations for Social Security Disability.

11.14.3.2 Services for which plastic surgery or other services are indicated primarily for cosmetic reasons.

11.14.3.3 Physical examinations required for obtaining continuing employment, insurance or governmental licensing.

11.14.3.4 Sports physicals

11.14.3.5 Experimental and Investigational Treatment or Services, determined in accord with Section 11.10, Experimental and Investigational Services, and services associated with experimental or investigational treatment or services.

11.14.3.6 Reversal of voluntary induced sterilization.

11.14.3.7 Personal Comfort Items, including but not limited to guest trays, television and telephone charges.

11.14.3.8 Biofeedback Therapy

11.14.3.9 Massage Therapy

11.14.3.10 Acupuncture

11.14.3.11 TMJ for Adults

11.14.3.12 Diagnosis and treatment of infertility, impotence, and sexual dysfunction.

11.14.3.13 Orthoptic (eye training) care for eye conditions

11.14.3.14 Naturopathy

11.14.3.15 Tissue or organ transplants that are not specifically listed as covered.

11.14.3.16 Immunizations required for international travel purposes only.

11.14.3.17 Court-ordered services

11.14.3.18 Any service provided to an incarcerated enrollee, beginning when a law enforcement officer takes the enrollee into legal custody and ending when the enrollee is no longer in legal custody.

11.14.3.19 Pharmaceutical products prescribed by any provider related to non- covered services.

11.14.3.20 Any service, product, or supply paid for by DSHS under its fee-for-service program only on an exception to policy basis.

11.14.3.21 Any other service, product, or supply not covered by DSHS under its fee-for-service program.

11.15 **Coordination of Benefits and Subrogation of Rights of Third Party Liability:**

11.15.1 Coordination of Benefits:

11.15.1.1 Until such time as DSHS shall terminate the enrollment of an enrollee who has comparable coverage as described in Section 2.9.3, the services and benefits available under this Contract shall be secondary to any other medical coverage.

11.15.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement of Section 8.6, Prohibition on Enrollee Charges for Covered Services. The Contractor shall:

11.15.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

11.15.1.2.2 Attempt to recover any third-party resources available to enrollees (42 CFR 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

11.15.1.2.3 Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 CFR 433.139(b)(3)).

11.15.1.2.4 Pay claims for covered services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 CFR 433.139(c)).

11.15.1.2.5 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

11.15.2 Subrogation Rights of Third-Party Liability:

11.15.2.1 Injured person means an enrollee covered by this Contract who sustains bodily injury.

11.15.2.2 Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

11.15.2.3 If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

11.15.2.4 HCA and DSHS specifically assign to the Contractor the HCA's and DSHS' rights to such third party payments for medical care provided to an enrollee on behalf of HCA and DSHS, which the enrollee assigned to DSHS as provided in WAC 388-505-0540.

11.15.2.5 DSHS also assigns to the Contractor its statutory lien under RCW 43.20B.060. The Contractor shall be subrogated to the DSHS' rights and remedies under RCW 74.09.180 and RCW 43.20B.040 through RCW 43.20B.070 with respect to medical benefits provided to enrollees on behalf of DSHS under RCW 74.09.

11.15.2.6 The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

11.15.2.7 The Contractor shall notify DSHS of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 43.20B.050.

12. GENERAL TERMS AND CONDITIONS

12.1 **Amendment:** This Contract, or any term or condition, may be modified or extended by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

12.2 **Assignment of this Contract:** The Contractor shall not assign this Contract, including the rights, benefits and duties hereunder, without obtaining the express written consent of HCA. HCA shall not recognize any assignment made without such prior written consent. In the event that consent is given and this Contract is

assigned, all terms and conditions of this Contract shall be binding upon the Contractor's successors and assignees.

12.3 **Access to Facilities and Records:** The Contractor and its subcontractors shall cooperate with audits performed by duly authorized representatives of HCA, DSHS, the State of Washington, the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, the quality, cost, use, health and safety and timeliness of services, and assessment of the Contractor's capacity to bear the potential financial losses. The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this Contract for Medicaid fraud investigators (42 CFR 438.6).

12.4 **Compliance with All Applicable Laws and Regulations:** In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract (42 CFR 438.100(d)). This includes, but is not limited to:

12.4.1 Title XIX and Title XXI of the Social Security Act;

12.4.2 Title VI of the Civil Rights Act of 1964;

12.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities;

12.4.4 The Age Discrimination Act of 1975;

12.4.5 The Rehabilitation Act of 1973;

12.4.6 All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

12.4.6.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, DHHS, and the EPA.

12.4.6.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan,

issued in compliance with the Federal Energy Policy and Conservation Act.

12.4.6.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

12.4.6.4 Those specified in Title 18 RCW for professional licensing.

12.4.6.5 Industrial Insurance – Title 51 RCW.

12.4.6.6 Reporting of abuse as required by RCW 26.44.030.

12.4.6.7 Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2.

12.4.6.8 EEO Provisions.

12.4.6.9 Copeland Anti-Kickback Act.

12.4.6.10 Davis-Bacon Act.

12.4.6.11 Byrd Anti-Lobbying Amendment.

12.4.6.12 All federal and state nondiscrimination laws and regulations.

12.4.6.13 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all covered services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining covered services.

12.4.6.14 Any other requirements associated with the receipt of federal funds.

12.5 **Complete Contract:** This Contract incorporates exhibits to this Contract and the DSHS billing instructions applicable to the Contractor. All terms and conditions of this Contract are stated in this Contract and its incorporations. No other agreements, oral or written, are binding.

12.6 **Confidentiality:** The Contractor may use Personal Information and other information gained by reason of this Contract only for the purpose of this Contract. The Contractor shall not disclose, transfer or sell any such information to any party, including but not limited to medical records, except as provided by law or, in the case of Personal Information, with the prior written consent of the person to whom the Personal Information pertains or their legal guardian. The Contractor shall maintain and protect the confidentiality of all Personal Information and other information gained by reason of this Contract. Upon written request by DSHS and HCA, the Contractor shall either return or destroy and certify destruction of all Personal Information.

12.6.1 The Contractor, HCA and DSHS agree to share Personal Information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164., the HIPAA regulations, 42 CFR 431 Subpart F, RCW 5.60.060(4), and RCW 70.02). The Contractor and the Contractor's subcontractors shall fully cooperate with HCA and DSHS efforts to implement HIPAA requirements.

12.6.2 The Contractor shall have policies and procedures in place to address the protection and destruction of retained enrollee Personal Information data shared by HCA and DSHS with the Contractor.

12.6.2.1 The Contractor's policies and procedures related to the protection and destruction of retained enrollee Personal Information data shall include the following:

12.6.2.1.1 Written policies, procedures, and standards of conduct that articulates the Contractor's compliance with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164., the HIPAA regulations, 42 CFR 431 Subpart F, RCW 5.60.060(4), and RCW 70.02).

12.6.2.1.2 Identification of who will have access to and the extent of security measures implemented to protect retained enrollee Personal Information data.

12.6.2.1.3 Identification of the methods the Contractor will use to destroy retained enrollee Personal Information data shared by HCA and DSHS with the Contractor.

12.6.2.1.4 Provision for internal and external monitoring and auditing of compliance with the Contractors policies and procedures to protect retained enrollee Personal Information data.

12.6.2.1.5 Provision for prompt response to detected security offenses and for the development of corrective action related to the protection and destruction of retained enrollee Personal Information data.

12.6.2.2 The policies and procedures to protect retained enrollee Personal Information data will be submitted to DSHS for approval, according to Section 12.26, Notices, by January 31st each year of this Contract. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The

Contractor shall have thirty (30) calendar days to resubmit the policies and procedures. If the policies and procedures to protect retained enrollee Personal Information data have been approved by DSHS for the previous year and they are unchanged, the Contractor shall not be required to resubmit them but instead shall certify in writing to DSHS that they are unchanged, in accord with Section 12.26, Notices.

12.6.3 Retained enrollee Personal Information data will be maintained throughout the life cycle of the data, to include any record retention cycle, as described in Section 12.30.2, or archival period, in a manner that will retain its confidential nature regardless of the age or media format of the data.

12.7 **Contractor Certification Regarding Ethics:** The Contractor certifies that the Contractor is now, and shall remain, in compliance with Chapter 42.52 RCW, Ethics in Public Services, throughout the term of this Contract.

12.8 **Covenant Against Contingent Fees:** The Contractor certifies that no person or agency has been employed or retained on a contingent fee for the purpose of seeking or obtaining this Contract. This does not apply to legitimate employees or an established commercial or selling agency maintained by the Contractor for the purpose of securing business. In the event of breach of this clause by the Contractor, HCA may, at its discretion: a) annul the Contract without any liability; or b) deduct from the Contract price or consideration or otherwise recover the full amount of any such contingent fee.

12.9 **Data Certification Requirements**: Any information and/or data required by this Contract and submitted to DSHS after April 1, 2005 shall be certified by the Contractor as follows (42 CFR 438.600 through 42 CFR 438.606):

12.9.1 Source of certification: The information and/or data shall be certified by one of the following:

12.9.1.1 The Contractor's Chief Executive Officer.

12.9.1.2 The Contractor's Chief Financial Officer.

12.9.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

12.9.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

12.9.3 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

12.9.4 Data that must be certified include documents specified by DSHS.

12.10 **Disputes:** When a dispute arises over an issue that pertains in any way to this Contract, the parties agree to the following process to address the dispute:

12.10.1 The Contractor, HCA and DSHS shall attempt to resolve the dispute through informal means between the Contractor, the HCA contract manager, and the Office Chief of the DSHS, Division of Program Support, Office of Managed Care.

12.10.2 If the Contractor is not satisfied with the outcome of the informal resolution , the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the outcome, to:

Barney Speight, Deputy Administrator
Health Care Authority
P.O. Box 427000
Olympia, WA 98504-2700

and

MaryAnne Lindeblad, Director (or her successor)
Department of Social and Health Services
Division of Program Support
P.O. Box 45530
Olympia, WA 98504-5530

The Deputy Administrator and Director may request additional information from the HCA contract manager, DSHS Office Chief and/or the Contractor. The Deputy Administrator and Director shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor according to Section 12.26, Notices.

12.10.3 When the Contractor disagrees with the review decision of the Deputy Administrator and Director, the Contractor may request independent mediation of the dispute. The request for mediation must be submitted to the Deputy Administrator and Director, in writing, within ten (10) working days of the contractor's receipt of the Deputy Administrator's and Director's review decision. The Contractor, HCA and DSHS shall mutually agree on the selection of the independent mediator and shall bear all costs associated with mediation equally. The results of mediation shall not be binding on either party.

12.10.4 All parties agree to make their best efforts to resolve disputes arising from this Contract and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this Contract.

12.11 **HCA and DSHS Not Guarantor:** The Contractor acknowledges and certifies that neither HCA or DSHS nor the State of Washington are guarantors of any obligations or debts of the Contractor.

12.12 **Exclusions and Debarment:**

12.12.1 The Contractor certifies that the Contractor has not been debarred, suspended or otherwise excluded by any federal agency. The Contractor certifies that it does not knowingly have a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of the Contractor's equity, or have an employee, consultant or subcontractor who is significant or material to the provision of services under this Contract, who has been, or is affiliated with someone who has been debarred, suspended, or otherwise excluded by any federal agency (SSA 1932(d)(1)). A list of debarred, suspended or otherwise excluded parties is available on the following Internet website: www.arnet.gov/epls.

12.12.2 By entering into this Contract, the Contractor certifies that it does not knowingly have anyone who is an excluded person, or is affiliated with an excluded person, as a director, officer, partner, employee, contractor, or person with a beneficial ownership of more than five percent (5%) of its equity.

12.12.3 The Contractor is not required to consult the excluded parties list, but may instead rely on certification from directors, officers, partners, employees, contractors, or persons with beneficial ownership of more than five percent (5%) of the Contractor's equity, that they are not debarred or excluded from a federal program.

12.12.4 The Contractor is required to notify HCA and DSHS, in accord with Section 12.26, Notices, when circumstances change that affect such certifications referenced in Sections 12.1.2, 12.1.2 and 12.1.3.

12.13 **Five Percent Equity**: The Contractor shall provide to DSHS, according to Section 12.26, Notices, a list of persons with a beneficial ownership of more than five percent (5%) of the Contractor's equity no later than February 28 of each year of this Contract.

12.14 **Force Majeure**: If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other

than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

12.15 **Fraud and Abuse Requirements – Policies and Procedures:**

12.15.1 The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse (42 CFR 438.608(a)).

12.15.2 The Contractor's arrangements or procedures shall include the following (42 CFR 438.608(b)(1)):

12.15.2.1 Written policies, procedures, and standards of conduct that articulates the Contractor's commitment to comply with all applicable federal and state standards.

12.15.2.2 The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.15.2.3 Effective training for the compliance officer and the Contractor's employees.

12.15.2.4 Effective lines of communication between the compliance officer and the Contractor's staff.

12.15.2.5 Enforcement of standards through well-publicized disciplinary guidelines.

12.15.2.6 Provision for internal monitoring and auditing.

12.15.2.7 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.15.3 The Contractor shall submit a written copy of its administrative and management arrangement or procedures and mandatory compliance plan regarding fraud and abuse to DSHS for approval, according to Section 12.26, Notices, by March 31 each year of this Contract. DSHS shall respond with approval or denial with required modifications within thirty (30) calendar days of receipt. The Contractor shall have thirty (30) calendar days to resubmit the policies and procedures. If the administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse have been approved by DSHS for the previous year and they are unchanged, the Contractor shall not be required to resubmit them but instead shall certify in writing to DSHS that they are unchanged, in accord with Section 12.26, Notices.

12.15.4 The Contractor may request a copy of the guidelines that DSHS will use in evaluating the Contractor's written administrative and management

arrangements or procedures and mandatory compliance plan regarding fraud and abuse, and may request technical assistance in preparing the written administrative and management arrangements or procedures and mandatory compliance plan regarding fraud and abuse, by contacting the DSHS, Office of Managed Care e-mail box at healthyoptions@dshs.wa.gov.

12.16 **Fraud and Abuse Reporting:** The Contractor shall report in writing all verified cases of fraud and abuse, including fraud and abuse by the Contractor's employees and subcontractors, within seven (7) calendar days to HCA and DSHS according to Section 12.26, Notices. The

report shall include the following information:

12.16.1 Subject(s) of complaint by name and either provider/subcontractor type or employee position.

12.16.2 Source of complaint by name and provider/subcontractor type or employee position, if applicable.

12.16.3 Nature of complaint.

12.16.4 Estimate of the amount of funds involved.

12.16.5 Legal and administrative disposition of case.

12.17 **Governing Law and Venue:** This Contract shall be governed by the laws of the State of Washington. In the event of any legal action brought hereunder, venue shall be proper only in Thurston County, Washington. By execution of this Contract, the Contractor acknowledges the jurisdiction of the courts of the State of Washington regarding this matter.

12.18 **Headings not Controlling:** The headings and the index used herein are for reference and convenience only, and shall not enter into the interpretation of this Contract, or describe the scope or intent of any provisions or sections thereof.

12.19 **Health and Safety:** The Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any HCA enrollee or DSHS client with whom the Contractor has contact.

12.20 **Health Information Systems:** The Contractor shall maintain and shall require subcontractors to maintain a health information system that complies with the requirements of 42 CFR 438.242 and provides the information necessary to meet the Contractor's obligations under this Contract. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The health information system must:

12.20.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

12.20.2 Ensure data received from providers is accurate and complete by:

12.20.2.1 Verifying the accuracy and timeliness of reported data;

12.20.2.2 Screening the data for completeness, logic, and consistency; and

12.20.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

12.20.3 The Contractor shall make all collected data available to HCA, DSHS and the Center for Medicare and Medicaid Services (CMS) upon request.

12.21 **Independent Contractor:** The Contractor acknowledges that the Contractor is an independent Contractor, and certifies that none of its directors, officers, partners, employees, or agents are officers, employees, or agents of HCA, DSHS or the State of Washington. Neither the Contractor nor any of its directors, officers, partners, employees, or agents shall hold themselves out as, or claim to be, an officer, employee, or agent of HCA, DSHS or the State of Washington by reason of this Contract. Neither the Contractor nor any of its directors, officers, partners, employees, or agents shall claim any rights, privileges, or benefits that would accrue to a civil service employee under RCW 41.06.

12.21.1 Contractor shall be responsible for the payment of its internal administrative costs, including but not limited to federal, state and social security tax payments. The Contractor shall indemnify and hold HCA and DSHS harmless from all obligations to pay or withhold federal or state taxes or contributions on behalf of the Contractor or the Contractor's employees.

12.22 **Insolvency:**

12.22.1 If the Contractor becomes insolvent during the term of this Contract:

12.22.1.1 The State of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor;

12.22.1.2 In accord with Section 8.6, Prohibition on Enrollee Charges for Covered Services, under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for covered services.

12.22.1.3 The Contractor shall, in accord with RCW 48.44.055, or RCW 48.46.245, provide for the continuity of care for enrollees.

12.23 **Insurance:** The Contractor shall at all times comply with the following insurance requirements:

12.23.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. HCA, DSHS, the State of Washington,

its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this Contract.

12.23.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

12.23.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington, HCA and DSHS shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

12.23.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

12.23.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA or DSHS if requested.

12.23.6 Separation of Insureds: All insurance Commercial General Liability policies shall contain a "separation of insureds" provision.

12.23.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the State of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by the DSHS. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

12.23.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices Section of this Contract, Section 12.26, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

12.23.9 Material Changes: The Contractor shall give HCA and DSHS, in accord with the Notices Section of this Contract, Section 12.26, 45 days' advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA and DSHS ten (10) days' advance notice of cancellation.

12.23.10 General: By requiring insurance, the State of Washington, HCA and DSHS do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State, HCA and DSHS in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

Contractor may waive the requirements contained in Sections 12.23.1, 12.23.2, 12.23.7 and 12.23.8 if self-insured. In the event the Contractor is self insured, the Contractor must send to HCA and DSHS by January 15, 2006, a signed written document, which certifies that the contractor is self insured, carries coverage adequate to meet the requirements of Section 12.23, will treat HCA and DSHS as additional insureds, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA and DSHS.

12.24 **Mutual Indemnification and Hold Harmless**: Each party shall be responsible for, and shall indemnify and hold the other party harmless from, all claims and/or damages to persons and/or property resulting from its own all negligent acts and omissions. The Contractor shall indemnify and hold harmless HCA and DSHS from any claims by non-participating providers related to the provision to enrollees of covered services under this Contract. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees

12.25 **No Federal or State Endorsement**: Award of this Contract does not indicate endorsement of the Contractor by CMS, the federal or state government or any similar entity. No federal funds have been used for lobbying purposes in connection with this Contract or managed care program.

12.26 **Notices**:

12.26.1 Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if mailed by United States Postal Services, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

12.26.2 In the case of notice to the Contractor, notice will be sent to the Contractor Contact at the address for the Contractor on the first page of this Contract.

In the case of notice to HCA:

Anton Cooper, BH Procurement Manager (or successor)
676 Woodland Square Loop SE
P.O. Box 42710
Olympia, WA 98504-2710

In the case of notice to DSHS:

Peggy Wilson, Office Chief (or successor)
Department of Social and Health Services
Division of Program Support
Office of Managed Care
P.O. Box 45530
Olympia, WA 98504-5530

Said notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accord with this Section, stating the change and setting forth the new address, which shall be effective on the tenth (10^{th}) day following the effective date of such notice unless a later date is specified.

12.27 **Order of Precedence**: In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

12.27.1 Title XIX of the federal Social Security Act of 1935, as amended, and its implementing regulations, as well as federal statutes and regulations concerning the operation of Managed Care Organizations.

12.27.2 State of Washington statues and regulations concerning the operation of the HCA programs participating in this Contract including but not limited to WAC chapter 182-25 (Washington Basic Health Plan).

12.27.3 State of Washington statues and regulations concerning the operation of the DSHS programs participating in this Contract, including but not limited to WAC chapters 388-538 (Managed Care), 388-865 (Mental Health) and 388-805 (DASA) WAC.

12.27.4 State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.

12.27.5 General Terms and Conditions of this Contract.

12.27.6 Any other term and condition of this Contract and exhibits if any, as indicated on page one of this Contract.

12.27.7 DSHS solicitation documents associated with this Contract.

12.27.8 Any other material incorporated herein by reference.

12.28 **Program Information**: At the Contractor's request, DSHS shall provide the Contractor with pertinent documents including statutes, regulations, and current versions of billing instructions and other written documents which describe DSHS policies and guidelines related to service coverage and reimbursement (see Attachment A for website link).

12.29 **Proprietary Rights**: HCA recognizes that nothing in this Contract shall give HCA ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by HCA or DSHS during the performance of this Contract.

12.30 **Records Maintenance and Retention**:

12.30.1 Maintenance: The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

12.30.2 Retention: All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.

12.31 **Sanctions**:

12.31.1 If the Contractor fails to meet one or more of its obligations under the terms of this Contract, DSHS may impose sanctions by withholding up to five percent of its scheduled payments to the Contractor rather than terminating the Contract.

HCA or DSHS may withhold payment from the end the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

12.31.2 HCA or DSHS will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in Section 12.10, Disputes, if the Contractor disagrees with HCA's or DSHS' position.

12.31.3 DSHS, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210, against the Contractor for:

12.31.3.1 Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an enrollee covered under this Contract.

12.31.3.2 Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

12.31.3.3 Acting to discriminate against enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services.

12.31.3.4 Misrepresenting or falsifying information that it furnishes to CMS, DSHS, an enrollee, potential enrollee or any of its subcontractors.

12.31.3.5 Failing to comply with the requirements for physician incentive plans.

12.31.3.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by DSHS or that contain false or materially misleading information.

12.31.3.7 Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

12.31.3.8 Intermediate sanctions may include:

12.31.3.8.1 Civil monetary penalties in the following amounts:

12.31.3.8.1.1 A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to

enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations;

12.31.3.8.1.2 A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or DSHS;

12.31.3.8.1.3 A maximum of $15,000 for each potential enrollee DSHS determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit; and

12.31.3.8.1.4 A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under managed care. DSHS will deduct from the penalty the amount charged and return it to the enrollee.

12.31.3.8.2 Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. DSHS will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033.

12.31.3.8.3 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. DSHS shall notify current enrollees of the sanctions and that they may terminate enrollment at any time.

12.31.3.8.4 Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DSHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

12.32 **Severability**: The terms and conditions of this Contract are severable. If any term or condition of this Contract is held invalid by any court, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

12.33 **Solvency**:

12.33.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapter 48.44 or 48.46 RCW, as amended.

12.33.2 The Contractor agrees that HCA and DSHS may at any time access any information related to the Contractor’s financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.

12.34 **State Conflict of Interest Safeguards**: The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public contracting (41 USC 423).

12.35 **Survivability**:

12.35.1 The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Confidentiality, Indemnification and Hold Harmless, Access to Facilities and Records, and Maintenance of Records.

12.35.2 After termination of this Contract, the Contractor remains obligated to:

12.35.2.1 Cover hospitalized enrollees until discharge consistent with Section 11.11, Enrollees Hospitalized at Disenrollment.

12.35.2.2 Submit reports required in this Contract.

12.35.2.3 Provide access to records required in Section 12.3, Access to Facilities and Records.

12.35.2.4 Provide the administrative services associated with covered services (e.g. claims processing, enrollee appeals) provide to enrollees under the terms of this Contract.

12.36 **Termination by the Contractor for Default**: The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice specifying the default. For purposes of this Section, default means failure of HCA to meet one or more material obligations of this Contract. In the event it is determined that HCA was not in default, HCA may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

12.37 **Termination by HCA for Default**: The Contract Administrator may terminate this Contract whenever the Contractor defaults in performance of this Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as HCA may allow) after receipt from HCA or DSHS of a written notice specifying the default. For purposes of this Section, default means failure of the Contractor to meet one or more material obligations of this

Contract. In the event it is determined that the Contractor was not in default, the Contractor may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

12.38 **Termination for Reduction in Funding**: In the event funding from state, federal, or other sources is withdrawn, reduced or limited in any way after the effective date of this Contract and prior to the termination date, HCA may terminate this Contract under the "Termination for Convenience" clause.

12.39 **Termination - Information on Outstanding Claims:** In the event this agreement is terminated, the Contractor shall provide HCA and DSHS, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of Section 4, Payment.

12.40 **Terminations - Pre-termination Processes:**

12.40.1 Either party to the Contract shall give the other party to the Contract written notice of the intent to terminate this Contract and the reason for termination.

12.40.2 If either party disagrees with the other party's decision to terminate this Contract, other than for reduction in funding, that party will have the right to a dispute resolution as described in Section 12.10, Disputes.

12.40.3 If the Contractor disagrees with an HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. DSHS shall:

12.40.3.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

12.40.3.2 Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

12.40.3.3 For an affirming decision, give enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

12.41 **Washington Public Disclosure Act**: The Contractor acknowledges that HCA and DSHS are subject to the Public Records Act (the Act, which is codified at RCW 42.17.250, et seq.). This Contract will be a 'public record' as defined in RCW 42.17.020. Any documents submitted to HCA or DSHS by the Contractor may also be construed as 'public records' and therefore subject to public disclosure under the Act. The Contractor may label documents submitted to

HCA and DSHS as 'confidential' or 'proprietary' if it so chooses; however, the Contractor acknowledges that such labels are not determinative of whether the documents are subject to disclosure under the Act. If HCA or DSHS receives a public disclosure request that

would encompass any Contractor document that has been labeled by the Contractor as 'confidential' or 'proprietary,' then HCA or DSHS will notify the Contractor pursuant to RCW 42.17.330. The Contractor then will have the option, under RCW 42.17.330, of seeking judicial intervention to prevent the public disclosure of the affected document(s).

12.42 **Waiver**: Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract as amended as set forth in Section 12.1, Amendment. The failure of either party to enforce any provision of this Contract shall not constitute a waiver of that or any other provision, and will not be construed to be a modification of the terms and conditions of the Contract.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213 A (DHS Rev 7/04)

	AGREEMENT NUMBER	AMENDMENT NUMBER
☒ CHECK HERE IF ADDITIONAL PAGES ARE ADDED **6** PAGES	**95-23637**	**A-17**
	REGISTRATION NUMBER:	

1. This Agreement is entered into between the State Agency and Contractor named below:
STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)

California Department of Health Services
CONTRACTOR'S NAME (Also referred to as Contractor)
Molina Healthcare of California Partner Plan, Inc.

2. The term of this Agreement is 4/02/96 through 3/31/07

3. The maximum amount of this Agreement is: **$** 1,212,332,870 One Billion, Two Hundred Twelve Million, Three Hundred Thirty-Two Thousand, Eight Hundred Seventy Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. Amendment effective date: October 1, 2005

II. Purpose of amendment: The purpose of this amendment is to implement Medicare Part D contract language effective 1/1/06; to decrease the encumbered amount of the contract for FY 2005-2006 by $1,739,620, for FY 2006-2007 by $1,352,221, for a combined total decrease of $3,091,841; to implement the annual rate redetermination for the 2005-2006 Rate Period (10/1/05 - 12/31/05); and to implement the Medicare Part D rate adjustment for the period 01/01/06-9/30/06.

III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline.** Text deletions are displayed as strike through text (i.e., ~~Strike~~).

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is decreased by $3,091,841 and is amended to read: ~~$1,215,424,711 (One Billion, Two Hundred Fifteen Million, Four Hundred Twenty-Four Thousand, Seven Hundred Eleven Dollars.)~~**$1,212,332,870 (One Billion, Two Hundred Twelve Million, Three Hundred Thirty-Two Thousand, Eight Hundred Seventy Dollars).**

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Molina Healthcare of California Partner Plan, Inc.

BY *(Authorized Signature)* DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Joann Zarza-Garrido, CEO

ADDRESS
One Golden Shore Drive, Long Beach, CA 90802

CALIFORNIA
Department of General Services
Use Only

STATE OF CALIFORNIA

AGENCY NAME
California Department of Health Services

BY *(Authorized Signature)* DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Terri L. Anderson, Chief, Contracts and Purchasing Services Section

ADDRESS
1501 Capitol Avenue, Room 71.2101, MS 1403, P.O. Box 997413
Sacramento, CA 95899-7413

☒ Exempt per:W&I Code 14087.4

V. Exhibit A, Attachment 10, Scope of Services, Provision 1., Covered Services, is amended to read:

1. Covered Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract.

Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare & Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC 1395(x) et seq.

VI. Exhibit B, Budget Detail and Payment Provisions, Provision 2., Amounts Payable, is amended to read:

2. Amounts Payable

The amounts payable under this agreement shall not exceed:

A. $32,080,630 for the 1995-96 Fiscal Year ending June 30, 1996.
B. $194,472,680 for the 1996-97 Fiscal Year ending June 30, 1997.
C. $6,500,000 for the 1997-98 Fiscal Year ending June 30, 1998.
D. $80,000,000 for the 1998-99 Fiscal Year ending June 30, 1999.
E. $107,000,000 for the 1999-00 Fiscal Year ending June 30, 2000.
F. $107,000,000 for the 2000-01 Fiscal Year ending June 30, 2001.
G. $107,000,000 for the 2001-02 Fiscal Year ending June 30, 2002.
H. $108,041,631 for the 2002-03 Fiscal Year ending June 30, 2003.
I. $114,083,000 for the 2003-04 Fiscal Year ending June 30, 2004.
J. $126,461,929 for the 2004-05 Fiscal Year ending June 30, 2005.
K. ~~$130,965,620~~**$129,226,000** for the 2005-06 Fiscal Year ending June 30, 2006.
L. ~~$101,819,221~~**$100,467,000** for the 2006-07 Fiscal Year ending June 30, 2007.

The maximum amount payable for this Contract shall not exceed ~~$1,215,424,711~~ **$1,212,332,870**.

VII. Exhibit B, Budget Detail and Payment Provisions, Provision 4., Capitation Rates, is amended to add the Capitation Rate Tables included below. Paragraph B remains unchanged. Paragraph C is amended to read as indicted herein:

4. Capitation Rates

A. DHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on the first day of operations, as determined by DHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates at the end of the month:

For the period 10/01/05 – 12/31/05 **Riverside**

Groups	Aid Codes	Rate
Family	**01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R**	**$ 92.71**
Disabled	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 2E**	**$ 341.21**
Aged	**10, 14, 16, 18, 1E, 1H**	**$ 242.74**
Adult	**86**	**$ 504.39**
AIDS Beneficiary		**$ 1,304.01**
Breast and Cervical Cancer Treatment Program	**0M, 0N, 0P, 0R, 0T, 0U**	**$ 836.89**

For the period 10/01/05 – 12/31/05 **San Bernardino**

Groups	Aid Codes	Rate
Family	**01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R**	**$ 95.17**
Disabled	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E**	**$ 332.67**
Aged	**10, 14, 16, 18, 1E, 1H**	**$ 251.24**
Adult	**86**	**$ 516.98**
AIDS Beneficiary		**$ 1,338.04**
Breast and Cervical Cancer Treatment Program	**0M, 0N, 0P, 0R, 0T, 0U**	**$ 857.78**

MEDI-CAL ONLY

For the period 01/01/06 – 09/30/06 **Riverside**

Groups	Aid Codes	Rate
Family	**01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R**	**$ 92.71**
Disabled	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E**	**$ 369.30**
Aged	**10, 14, 16, 18, 1E, 1H**	**$ 351.20**
Adult	**86**	**$ 504.39**
AIDS Beneficiary		**$ 1,503.90**
Breast and Cervical Cancer Treatment Program	**0M, 0N, 0P, 0R, 0T, 0U**	**$ 836.89**

MEDI-CAL ONLY

For the period 01/01/06 – 09/30/06 **San Bernardino**

Groups	Aid Codes	Rate
Family	**01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R**	**$ 95.17**
Disabled	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E**	**$ 353.25**
Aged	**10, 14, 16, 18, 1E, 1H**	**$ 322.06**
Adult	**86**	**$ 516.98**
AIDS Beneficiary		$ 1,514.21
Breast and	**0M, 0N, 0P, 0R, 0T, 0U**	**$ 857.78**

Cervical Cancer Treatment Program		

DUAL ELIGIBLES – MEDI-CAL AND MEDICARE (Part D)

For the period 01/01/06 – 09/30/06 **Riverside**

Groups	Aid Codes	Rate
Disabled Duals	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E**	**$ 84.32**
Aged Duals	**10, 14, 16, 18, 1E, 1H**	**$ 104.43**
AIDS Beneficiary Duals		**$ 304.96**

DUAL ELIGIBLES – MEDI-CAL AND MEDICARE (Part D)

For the period 01/01/06 – 09/30/06 **San Bernardino**

Groups	Aid Codes	Rate
Disabled Duals	**20, 24, 26, 28, 36, 60, 64, 66, 68, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 2E**	**$ 81.53**
Aged Duals	**10, 14, 16, 18, 1E, 1H**	**$ 96.21**
AIDS Beneficiary Duals		**$ 307.58**

B. If DHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the monthly capitation rate specified for the original aid code. DHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practical after such aid code splits occur.

C. Pursuant to Title 42, Code of Federal Regulations, Section 438.6(c)(2)(ii), the actuarial basis for the computation of the capitation payment rates shall be set forth in DHS' most recent version of the annually-published Rate Manual for the rate period that is identified in the Capitation Rate Sheets attached hereto in Exhibit B, Attachment 1 (consisting of ~~12~~**30** pages). Said Rate Manual is hereby incorporated by reference as if fully set forth herein.

VIII. All other terms and conditions shall remain the same.

EXHIBIT 31.1

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended March 31, 2006 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2006

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended March 31, 2006 of Molina Healthcare, Inc.;

2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report;

3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in the report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, as amended), for the registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and

(d) Disclosed in the report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and to the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: May 9, 2006

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2006 (the "Report"), I, Joseph M. Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2006

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-Q for the period ended March 31, 2006 (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: May 9, 2006

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer