

STATE OF UTAH



SOLICITATION NO. NO10001

Childrens Health Insurance Program (CHIP) Medical Services

RESPONSES ARE DUE PRIOR TO:

Aug 24, 2009 3:00:00 PM MDT

RESPONSES MAY BE SUBMITTED ELECTRONICALLY TO:

www.bidsync.com

RESPONSES MAY BE MAILED OR DELIVERED TO:

State of Utah
Division of Purchasing
3150 State Office Building, Capitol Hill
Salt Lake City, Utah 84114-1061

Bid NO10001

Childrens Health Insurance Program (CHIP) Medical Services

Bid Number	NO10001
Bid Title	Childrens Health Insurance Program (CHIP) Medical Services
Bid Start Date	Jul 7, 2009 5:09:01 PM MDT
Bid End Date	Aug 24, 2009 3:00:00 PM MDT
Question & Answer End Date	Aug 10, 2009 3:00:00 PM MDT
Bid Contact	Nancy Orton Assistant Director Administrative Services
Contract Duration	3 years
Contract Renewal	2 annual renewals
Prices Good for	See Specifications
Bid Comments	Questions concerning this solicitation should be submitted via the BidSync electronic system. ----- If you have any trouble submitting your response or attaching documents in the BidSync site, please contact Vendor Customer Support at (801) 765-9245.

Item Response Form

Item	NO10001-1-01 - Childrens Health Insurance Program (CHIP) Medical Services
Quantity	1 contract
Prices are not requested for this item.	
Delivery Location	State of Utah
	<u>N/A</u>
	*
	* UT *
	Qty 1

Description

The purpose of this request for proposal is for the Utah Department of Health (Department) to enter into a contract with a qualified managed care plan or plans to provide health care services to enrollees of the Children's Health Insurance Program (CHIP). This RFP is specifically for the Intermountain network side of CHIP's medical services, per the attached specifications.



State of Utah Request for Proposal

Legal Company Name (include d/b/a if applicable) 	Federal Tax Identification Number 	State of Utah Sales Tax ID Number 	
Ordering Address 	City 	State 	Zip Code
Remittance Address (if different from ordering address)	City 	State 	Zip Code
Type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government	Company Contact Person 		
Telephone Number (include area code) 	Fax Number (include area code) 		
Company's Internet Web Address 	Email Address 		
Discount Terms (for bid purposes, bid discounts less than 30 days will not be considered)	Days Required for Delivery After Receipt of Order (see attached for any required minimums)		
The undersigned certifies that the goods or services offered are produced, mined, grown, manufactured, or performed in Utah. Yes ☐ No ☐ . If no, enter where produced, etc. 			
Offeror's Authorized Representative's Signature 	Date 		
Type or Print Name 	Position or Title 		

REQUEST FOR PROPOSAL - INSTRUCTIONS AND GENERAL PROVISIONS

1. SUBMITTING THE PROPOSAL: (a) The Utah Division of Purchasing and General Services (DIVISION) prefers that proposals be submitted electronically. Electronic proposals may be submitted through a secure mailbox at BidSync (formerly RFP Depot, LLC) (www.bidsync.com) until the date and time as indicated in this document. It is the sole responsibility of the supplier to ensure their proposal reaches BidSync before the closing date and time. There is no cost to the supplier to submit Utah's electronic proposals via BidSync. (b) Electronic proposals may require the uploading of electronic attachments. The submission of attachments containing embedded documents is prohibited. All documents should be attached as separate files. (c) If the supplier chooses to submit the proposal directly to the DIVISION in writing: The proposal must be signed in ink, sealed, and delivered to the Division of Purchasing, 3150 State Office Building, Capitol Hill, Salt Lake City, UT 84114-1061 by the "Due Date and Time." The "Solicitation Number" and "Due Date" must appear on the outside of the envelope. All prices and notations must be in ink or typewritten. Each item must be priced separately. Unit price shall be shown and a total price shall be entered for each item offered. Errors may be crossed out and corrections printed in ink or typewritten adjacent and must be initialed in ink by person signing offer. Unit price will govern, if there is an error in the extension. Written offers will be considered only if it is submitted on the forms provided by the DIVISION. (d) Proposals, modifications, or corrections received after the closing time on the "Due Date" will be considered late and handled in accordance with the Utah Procurement Rules, section R33-3-209. (e) Facsimile transmission of proposals to DIVISION will not be considered.

2. PROPOSAL PREPARATION: (a) Delivery time of products and services is critical and must be adhered to as specified. (b) Wherever in this document an item is defined by using a trade name of a manufacturer and/or model number, it is intended that the words, "or equivalent" apply. "Or equivalent" means any other brand that is equal in use, quality, economy and performance to the brand listed as determined by the DIVISION. If the supplier lists a trade name and/or catalog number in the offer, the DIVISION will assume the item meets the specifications unless the offer clearly states it is an alternate, and describes specifically how it differs from the item specified. All offers must include complete manufacturer's descriptive literature if quoting an equivalent product. All products are to be of new, unused condition, unless otherwise requested in this solicitation. (c) Incomplete proposals may be rejected. (d) Where applicable, all proposals must include complete manufacturer's descriptive literature. (e) By submitting the proposal the offeror certifies that all of the information provided is accurate, that they are willing and able to furnish the item(s) specified, and that prices offered are correct. (f) This proposal may not be withdrawn for a period of 60 days from the due date.

3. FREIGHT COST: (a) Where "Freight Cost" is listed as a separate line item, suppliers are to provide product line item pricing FOB Origin Less Freight. On the line item for "Freight Cost" suppliers are to indicate the total freight cost FOB Destination Freight Prepaid, and complete the "Freight Information" document. The DIVISION will analyze freight charges separately from the item cost and determine how the shipment will be routed (either by the supplier, or by the State's carrier). (b) Where there is not a line item for "Freight Cost", suppliers are to provide line item pricing FOB Destination Freight Prepaid. Unless otherwise indicated on the contract/purchase order, shipping terms will be FOB Destination Freight Prepaid.

4. SOLICITATION AMENDMENTS: All changes to this solicitation will be made through written addendum only. Answers to questions submitted through RFP Depot shall be considered addenda to the solicitation documents. Bidders are cautioned not to consider verbal modifications.

5. PROTECTED INFORMATION: Suppliers are required to mark any specific information contained in their offer which they are claiming as protected and not to be disclosed to the public or used for purposes other than the evaluation of the offer. Each request for non-disclosure must be made by completing the "Confidentiality Claim Form" located at:

<http://www.purchasing.utah.gov/contract/documents/confidentialityclaimform.doc> with a specific justification explaining why the information is to be protected. Pricing and service elements of any proposal will not be considered proprietary. All material becomes the property of the DIVISION and may be returned only at the DIVISION's option.

6. BEST AND FINAL OFFERS: Discussions may be conducted with offerors who submit proposals determined to be reasonably susceptible of being selected for award for the purpose of assuring full understanding of, and responsiveness to, solicitation requirements. Prior to award, these offerors may be asked to submit best and final offers. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by a competing offeror.

7. SAMPLES: Samples of item(s) specified in this offer, brochures, etc., when required by the DIVISION, must be furnished free of expense to the DIVISION. Any item not destroyed by tests may, upon request made at the time the sample is furnished, be returned at the offeror's expense.

8. AWARD OF CONTRACT: (a) The contract will be awarded with reasonable promptness, by written notice, to the responsible offeror whose proposal is determined to be the most advantageous to the DIVISION, taking into consideration price and evaluation factors set forth in the RFP. No other factors or criteria will be used in the evaluation. The contract file shall contain the basis on which the award is made. Refer to Utah Code Annotated 65-56-408. (b) The DIVISION may accept any item or group of items, or overall best offer. The DIVISION can reject any or all proposals, and it can waive any informality, or technicality in any proposal received, if the DIVISION believes it would serve the best interests of the DIVISION. (c) Before, or after, the award of a contract the DIVISION has the right to inspect the offeror's premises and all business records to determine the offeror's ability to meet contract requirements. (d) The DIVISION will open proposals publicly, identifying only the names of the offerors. During the evaluation process, proposals will be seen only by authorized DIVISION staff and those selected by DIVISION to evaluate the proposals. Following the award decision, all proposals become public information except for protected information (see number 5 above). A register of proposals and contract awards are posted at <http://purchasing.utah.gov/vendor/bidtab.html>. (e) Estimated quantities are for bidding purposes only, and not to be interpreted as a guarantee to purchase any amount. (f) Utah has a reciprocal preference law which will be applied against offerors offering products or services produced in states which discriminate against Utah products. For details see Section 63G-6-404 and 63G-6-405, Utah Code Annotated. (g) Multiple contracts may be awarded if the DIVISION determines it would be in its best interest.

9. DIVISION APPROVAL: Contracts written with the State of Utah, as a result of this proposal, will not be legally binding without the written approval of the Director of the DIVISION.

10. DEBARMENT: The CONTRACTOR certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction (contract) by any governmental department or agency. If the CONTRACTOR cannot certify this statement, attach a written explanation for review by the DIVISION.

11. ENERGY CONSERVATION AND RECYCLED PRODUCTS: The contractor is encouraged to offer Energy Star certified products or products that meet FEMP (Federal Energy Management Program) standards for energy consumption. The State of Utah also encourages contractors to offer products that are produced with recycled materials, where appropriate, unless otherwise requested in this solicitation.

12. GOVERNING LAWS AND REGULATIONS: All State purchases are subject to the Utah Procurement Code, Title 63, Chapter 56 Utah Code Annotated 1953, as amended, and the Procurement Rules as adopted by the Utah State Procurement Policy Board (Utah Administrative Code Section R33). These are available on the Internet at www.purchasing.utah.gov.

13. SALES TAX ID NUMBER: Utah Code Annotated (UCA) 59-12-106 requires anyone filing a bid with the state for the sale of tangible personal property or any other taxable transaction under UCA 59-12-103(1) to include their Utah sales tax license number with their bid. For information regarding a Utah sales tax license see the Utah State Tax Commission's website at www.tax.utah.gov/sales. The Tax Commission is located at 210 North 1950 West, Salt Lake City, UT 84134, and can be reached by phone at (801) 297-2200.

(Revision 22 October 2008 - RFP Instructions)

REQUEST FOR PROPOSAL
(CHIP 2009 Medical RFP)
Solicitation #NO10001

PURPOSE OF REQUEST FOR PROPOSAL (RFP)

The purpose of this request for proposal is for the Utah Department of Health (Department) to enter into a contract with a qualified managed care plan or plans to provide health care services to enrollees of the Children's Health Insurance Program (CHIP). This RFP is specifically for the Intermountain network side of CHIP's medical services. It is anticipated that this RFP will result in a contract award to one contractor with a statewide network of providers.

This RFP is designed to provide interested Offerors with sufficient basic information to submit proposals meeting minimum requirements, but is not intended to limit a proposal's content or exclude any relevant or essential data. Offerors are at liberty and are encouraged to expand upon the specifications to evidence service capability under any agreement.

The Department reserves the right to verify the correctness of any information submitted by the Offeror. The Department may also ask for additional supporting information on any item. By submitting a proposal, the Offeror agrees to provide such additional information as requested by the Department.

BACKGROUND

CHIP provides health insurance to children from birth through age 18 from lower income families that do not qualify for Medicaid. CHIP was first authorized by Congress in 1997 and implemented in Utah in 1998. CHIP has contracted with several different health plans since its inception.

Attachment G has a list of the hospitals to which CHIP clients currently have access. This RFP is specifically for the Intermountain network side of CHIP's services. However, it is to the Offeror's benefit to have contracts with hospitals outside of the Intermountain network of hospitals.

ISSUING OFFICE AND RFP REFERENCE NUMBER

The State of Utah Division of Purchasing is the issuing office for this document and all subsequent addenda relating to it, on behalf of the Department. The reference number for the transaction is Solicitation #NO10001. This number must be referred to on all proposals, correspondence, and documentation relating to the RFP.

SUBMITTING YOUR PROPOSAL

Proposals must be received by the posted due date and time. Proposals received after the deadline will be late and ineligible for consideration.

The preferred method of submitting your proposal is electronically through BidSync. However, if you choose to submit hard copies, one original and seven identical copies of your proposal must be received at the State of Utah Division of Purchasing, 3150 State Office Building, Capitol Hill, P.O. Box 141061, Salt Lake City, Utah 84114-1061.

When submitting a proposal electronically through BidSync, please allow sufficient time to complete the online forms and upload documents. The solicitation will end at the closing time listed in the RFP. If you are in the middle of uploading your proposal at the closing time, the system will stop the process and your proposal will not be received by the system.

Electronic proposals may require uploading of electronic attachments. BidSync's site will accept a wide variety of document types as attachments (documents should be attached as separate files). The submission of documents containing embedded documents (zip files), mov, wmp, and mp3 files are prohibited.

LENGTH OF CONTRACT

The Contract resulting from this RFP will be for a period of three years with the possibility of two one-year extensions.

SCHEDULE

RFP Release Date	July 07, 2009
Proposal Due Date	August 24, 2009
Projected Date for Announcement of the Successful Offerors	September 21, 2009
Projected Contract Start Date (if possible)	January 1, 2010

The schedule is subject to change.

PRICE GUARANTEE PERIOD

All pricing must be guaranteed for one year. Following the guarantee period, any request for price adjustment must be done as stated in the contract. Requests for price adjustment must include sufficient documentation supporting the request. Any adjustment or amendment to the contract will not be effective unless approved by the State Director of Purchasing.

STANDARD CONTRACT GENERAL PROVISIONS

Any contract resulting from this RFP will include, but not be limited to, the State's General Provisions (see *Attachment A, General Provisions*).

QUESTIONS

All questions must be submitted through RFP Depot. Answers will be given via the RFP Depot site. Questions received after August 10, 2009 may not be answered.

DISCUSSIONS WITH OFFERORS (ORAL PRESENTATION)

An oral presentation by an offeror to clarify a proposal may be required at the sole discretion of the State. However, the State may award a contract based on the initial proposals received without discussion with the Offeror. If oral presentations are required, they will be scheduled after the submission of proposals. Oral presentations will be made at the Offeror's expense.

PROTECTED INFORMATION

The Government Records Access and Management Act (GRAMA), Utah Code Ann., Subsection 63-2-304, provides in part that:

the following records are protected if properly classified by a government entity:

(1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret has provided the governmental entity with the information specified in Section 63-2-308 (Business Confidentiality Claims);

(2) commercial information or non-individual financial information obtained from a person if:

(a) disclosure of the information could reasonably be expected to result in unfair competitive injury to the person submitting the information or would impair the ability of the governmental entity to obtain necessary information in the future;

(b) the person submitting the information has a greater interest in prohibiting access than the public in obtaining access; and

(c) the person submitting the information has provided the governmental entity with the information specified in Section 63-2-308;

** * * * **

(6) records the disclosure of which would impair governmental procurement proceedings or give an unfair advantage to any person proposing to enter into a contract or agreement with a governmental entity, except that this Subsection (6) does not restrict the right of a person to see bids submitted to or by a governmental entity after bidding has closed;

GRAMA provides that trade secrets, commercial information or non-individual financial information may be protected by submitting a Claim of Business Confidentiality.

To protect information under a Claim of Business Confidentiality, the Offeror must:

1. provide a written Claim of Business Confidentiality *at the time the information (proposal) is provided to the State*, and
2. include a concise statement of reasons supporting the claim of business confidentiality (Subsection 63-2-308(1)).
3. submit an electronic "redacted" (excluding protected information) copy of your proposal response. Copy must clearly be marked "Redacted Version."

A Claim of Business Confidentiality may be appropriate for information such as client lists and non-public financial statements. Pricing and service elements may not be protected. An entire proposal may not be protected under a Claim of Business Confidentiality. The claim of business confidentiality must be submitted with your proposal on the form which may be accessed at:

<http://www.purchasing.utah.gov/main/Contractinfo/ConfidentialityClaimForm.doc>

To ensure the information is protected, the Division of Purchasing asks the Offeror to clearly identify in the Executive Summary and in the body of the proposal any specific information for which an Offeror claims business confidentiality protection as "PROTECTED".

All materials submitted become the property of the State of Utah. Materials may be evaluated by anyone designated by the State as part of the proposal evaluation committee. Materials submitted may be returned only at the State's option.

DETAILED SCOPE OF WORK

The Offeror is expected to adhere to the scope of work as described in Attachments B - F.

COMPANY QUALIFICATIONS AND PROPOSAL REQUIREMENTS

Minimum Qualifications

1. Licensure. Participation in CHIP managed care is limited to organizations that are licensed by the Department of Insurance. The Department of Health will not award contracts to any organizations prior to their becoming licensed. Evidence of license should be submitted with the proposal.
2. Hospital Contracts or Letters of Intent to Contract. All Offerors must have a contract or letter of intent to contract with the following hospitals: (1) Primary Children's Medical Center, (2) Intermountain Medical Center, (3) McKay-Dee Medical Center, (4) Utah Valley Regional Medical Center, (5) Dixie Regional Medical Center, (6) Logan Regional Medical Center, (7) Gunnison Valley hospital, and (8) San Juan hospital.

Proposal Requirements

The Offeror must describe in adequate detail the following. Please do not exceed the maximum number of pages. Additional information may be included in an appendix, but may or may not be read by the Department.

The Department reserves the right to withdraw the offer to contract if the Department believes that the offeror will be unable to fulfill all material provisions of its offer in a timely manner. Such material provisions include, without limitation, the failure to finalize contracts with physicians, hospitals or other providers represented through letters of intent in the offeror's proposal.

1. Experience with Managed Care (1 page maximum)
 - a. Offeror's experience with managed care operating a group pool of 10,000 lives or more. Please provide the date the Offeror's company was established, the

number of years of *managed care experience* the Offeror has as an entity, and the number of people currently in the pool.

- b. Whether the company or any of its officers or directors has had any regulatory actions taken against them in the last five years. The Department may verify this information with regulatory agencies.

The Department reserves the right to not do business with companies that have had serious regulatory actions taken against them or their officers.

2. Quality Assurance (1 page maximum)

- a. Please provide information on whether the Offeror is NCQA accredited and if so, which type of accreditation outcome it has earned. Please provide official documentation (not included in the page limit).

3. Customer Service/ Consumer Satisfaction (5 page maximum)

Please provide information in the following areas:

- a. The member rating of the health plan in the most recent Consumer Assessment of Health Plans Survey (CAHPS) and the name of the vendor used. Please submit ratings for all lines of business the plan has: commercial, Medicaid, and CHIP.
- b. HEDIS measure for the 2008 measurement year (January 1, 2008 to December 31, 2008): Call Answer Timeliness

"The percentage of calls received by the organization's Member services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds."

- c. Average time for calendar year 2008 that it took the Offeror to send client ID cards from the time the Offeror was notified of a person's enrollment. Please designate days as business days or calendar days. Please designate whether the measure is for just Utah operations or across whole organization. Either is acceptable.

4. Statewide Networks, Provider Contracting and Discounts (20 page maximum)

Please provide information in the following areas:

- a. Complete the Attachment G worksheet, Hospital Groups, to declare all the hospitals state-wide the Offeror is currently contracted with OR for whom the

Offeror has signed letters of intent to contract. Although the focus of this RFP is the hospitals in group 1, it is to the Offeror's benefit to have contracts with other hospitals as well. The Offeror must have contracts or letters of intent with physicians with admitting and treatment privileges at each hospital listed in its network.

- b. A description of the coverage and capacity of the Offeror's physician network. Please also provide the following information:

1. The number of primary care providers for each county
2. A data file (preferably in Excel) listing physicians who are on the Health Plan's panel who will be serving CHIP clients. The physicians listed on the panel must either be contracted with the Health Plan or have a letter of intent to contract with the Health Plan. The data file should contain the following fields: Physician Name (Last, First Middle Initial), Business Street Address, City, County, State, Zip Code, and NPI Number. Please send the data file to aeliason@utah.gov.

Upon request, the Department will provide a data file with a list of the physicians on CHIP's current PEHP panels that are visited the most frequently. To request a data file with this provider list from the Department, please send an email to aeliason@utah.gov.

- c. The hospitals in the Offeror's selected hospital group that include inpatient mental health facilities.
- d. A description of the coverage and capacity of the Offeror's mental health provider network. Please also provide the following information:
1. The number of psychiatrists, psychologists, and licensed clinical social workers in the Offeror's network by local health department area. (See Attachment H, Local Health Departments, for a list of local health departments and counties that make up those local health departments)
- e. A description of how the Offeror assures that patients can get in to see their doctors.

Please also provide the following information:

1. Any standards for appointment scheduling for primary care providers for urgent care and routine care.
2. Other standards or measures in this area used by the Offeror.
3. The Offeror's procedures for measuring compliance with the above standard(s).

5. Management of Medical Expenses Including Mental Health Costs (10 page maximum)

Please provide information in the following areas:

- a. The Offeror's utilization management program. Please discuss at a minimum the Offeror's monitoring and management of mental health costs, ER visits, aberrant physician behavior, pharmacy utilization, and prescription drug abuse.
- b. Other methods the Offeror uses to assure appropriate utilization and promote high quality, cost effective care.

6. Pharmacy Benefit Management (5 page maximum)

Please provide information in the following areas:

- a. The reimbursement methodology based on Average Wholesale Price (AWP) for generic drugs. The Offeror should state the overall pharmacy discount from AWP.
- b. The reimbursement methodology based on AWP for brand name drugs. The Offeror should state the overall pharmacy discount from AWP.
- c. Manufacturer Rebates expected as a percentage of overall pharmacy costs annually.

7. Efficiency of Claim Paying Procedures (5 page maximum)

Please provide information in the following areas:

- a. How Third-Party Liabilities are identified, maintained and collected.
 1. *Subrogation*. Please discuss the identification, maintenance, and collection of third-party liabilities.
 2. *Coordination of Benefits*. Please describe the process for identifying and verifying other sources of health insurance coverage.
- b. The percentage of "clean" claims received in calendar year 2008 and paid within thirty days of receipt.
- c. The percentage of "clean" claims received in calendar year 2008 paid within ninety days of receipt.

"Clean" claims are claims that can be processed without obtaining additional information from the provider of the service or from a third party.

8. Financial Information

Please submit the following pieces of financial information:

- a. A copy of the Offeror's December 31, 2008 annual statement as filed with the National Association of Insurance Commissioners.
- b. The Offeror's most recent AM Best Rating.

The Department reserves the right to not do business with companies that it considers to be in financial trouble.

PROPOSAL RESPONSE FORMAT

All proposals must be organized and tabbed with labels for the following headings:

1. **RFP Form.** The State's Request for Proposal form completed and signed.
2. **Executive Summary.** The one or two page executive summary is to briefly describe the Offeror's proposal. This summary should highlight the major features of the proposal. It must indicate any requirements that cannot be met by the Offeror. The reader should be able to determine the essence of the proposal by reading the executive summary. Proprietary information requests should be identified in this section.
3. **Detailed Response.** This section should constitute the major portion of the proposal and must contain at least the following information:
 - A. A complete narrative of the Offeror's assessment of the work to be performed, the Offeror's ability and approach, and the resources necessary to fulfill the requirements. This should demonstrate the Offeror's understanding of the desired overall performance expectations. Clearly indicate any options or alternatives proposed.
 - B. A specific point-by-point response, in the order listed, to each requirement in the RFP.
4. **Cost Proposal.** Cost will be evaluated independently from the technical proposal. Please enumerate all costs on the attached Cost Proposal Form.

PROPOSAL EVALUATION CRITERIA

A committee will evaluate proposals against the criteria found in *Attachment J, RFP Evaluation Criteria*. Each area of the evaluation criteria must be addressed in detail in the proposal.

LIST OF ATTACHMENTS

Note that the description of the scope of work is contained in Attachments B, C, D, E, and F. More specific details on the scope of work may be provided in the contracting process.

Attachment A	General Provisions
Attachment B	Special Provisions
Attachment C	Covered Services, Limitations, Exclusions, and Co-Payment Requirements
Attachment D	Quality Assurance and Utilization Management
Attachment E	Cost and Utilization Reporting Forms and Definitions
Attachment F	Rates and Related Provisions
Attachment G	Hospital Groups
Attachment H	Local Health Department Boundaries
Attachment I	Cost Proposal Form
Attachment J	RFP Evaluation Criteria
Attachment K	Managed Care Experience Points Table
Attachment L	Hospital Network Scoring Worksheet
Attachment M	Cost Points Scoring Methodology
Attachment N	Evaluation Score Sheet

COST PROPOSAL

Cost is to be submitted based on the following:

Give one bid (PMPM) using *Attachment I, Cost Proposal Form* to provide all medically necessary services as described in *Attachment C, Covered Services, Limitations, Exclusions and Co-Payment Requirements*.

The contract resulting from this RFP will be a 100% risk contract for the Health Plan with no stop loss or savings/ loss sharing provisions. The Health Plan will bear complete responsibility and risk for all expenditures related to this contract, including but not limited to medical, pharmacy, administration, and any other costs. Accordingly, all savings or losses that result from the difference between premium reimbursements and expenditures will be retained by the Health Plan.

The number of enrollees the Offeror will receive cannot be guaranteed by the Department. PEHP, CHIP's current provider for the Intermountain network had a CHIP enrollment in April of 2009 of 23,228. Total CHIP enrollment in April 2009 was 39,767. The Department expects CHIP's enrollment to grow. In the 2008 legislative session, HB 326 passed which requires CHIP to keep enrollment open for eligible children.

CHIP's claims experience is available upon request by completing the following steps:

1. Submit a request for claims experience and a request for a Business Associate agreement to aeliason@utah.gov,
2. Complete and sign the Business Associate agreement,
3. Email a scanned, signed copy of the agreement to aeliason@utah.gov, and
4. Mail **two** originals to the following address:

Children's Health Insurance Program
Attention: Aaron Eliason
Utah Department of Health
PO Box 144102
Salt Lake City, UT 84114-4102

ATTACHMENT "A"
UTAH DEPARTMENT OF HEALTH
General Provisions - RFP
June 8, 2009

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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 an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals the lesser of (a) the capitalization level established by the Contractor for financial purposes, or (b) \$5,000.00, 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 6, Title 63G, 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.

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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 63G, 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

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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 11736850-010-STC. 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 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 (63G-6-1002, 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.

28. The Contractor agrees to maintain the security and integrity of any electronic media that contains confidential data procured or used pursuant to the undertaking of this agreement. At the termination of this agreement the Contractor shall certify in writing that all such confidential data has been disposed of in such a manner that it cannot be recovered or recreated. If, as part of this agreement, the Department has provided the Contractor with any type of electronic data storage device, the Contractor shall return all devices to the Department at the termination of this agreement.

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29. CERTIFY REGISTRATION AND USE OF EMPLOYMENT "STATUS VERIFICATION SYSTEM": The Status Verification System, also referred to as "E-verify", only applies to contracts issued through a Request for Proposal process, and to sole sources that are included within a Request for Proposal. It does not apply to Invitation to Bids nor to the Multi-Step Process.

29.1 Status Verification System

1. Each offeror and each person signing on behalf of any offeror certifies as to its own entity, under penalty of perjury, that the named Contractor has registered and is participating in the Status Verification System to verify the work eligibility status of the contractor's new employees that are employed in the State of Utah in accordance with UCA Section 63G-11-103.
2. The Contractor shall require that the following provision be placed in each subcontract at every tier: "The subcontractor shall certify to the main (prime or general) contractor by affidavit that the subcontractor has verified through the Status Verification System the employment status of each new employee of the respective subcontractor, all in accordance with Section 63G-11-103 and to comply with all applicable employee status verification laws. Such affidavit must be provided prior to the notice to proceed for the subcontractor to perform the work."
3. The State will not consider a proposal for award, nor will it make any award where there has not been compliance with this Section.
4. Manually or electronically signing the Proposal is deemed the Contractor's certification of compliance with all provisions of this employment status verification certification required by all applicable status verification laws including UCA Section 63G-11-103.

29.2 Indemnity Clause for Status Verification System

1. Contractor (includes, but is not limited to any Contractor, Design Professional, Designer or Consultant) shall protect, indemnify and hold harmless, the State and its officers, employees, agents, representatives and anyone that the State may be liable for, against any claim, damages or liability arising out of or resulting from violations of the above Status Verification System Section whether violated by employees, agents, or contractors of the following: (a) Contractor; (b) Subcontractor at any tier; and/or (c) any entity or person for whom the Contractor or Subcontractor may be liable.
2. Notwithstanding Section 1. above, Design Professionals or Designers under direct contract with the State shall only be required to indemnify the State for a liability claim that arises out of the design professional's services, unless the liability claim arises from the Design Professional's negligent act, wrongful act, error or omission, or other liability imposed by law except that the design professional shall be required to indemnify the State in regard to subcontractors or subconsultants at any tier that are under the direct or indirect control or responsibility of the Design Professional, and includes all independent contractors, agents, employees or anyone else for whom the Design Professional may be liable at any tier.

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

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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,

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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.

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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 of Utah Legal Compliance Audit Guide (SULCAG) as defined in Chapter 2a, Title 51, UCA. All federal and state principles and requirements cited in Table 1 are available on the Web at the addresses indicated. A Contractor who receives federal or state funds may be subject to federal and state reporting requirements. A Contractor who receives \$500,000 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 reports shall be sent to the Utah Department of Health, Bureau of Financial Audit, Box 144002, Salt Lake City, Utah 84114-4002.

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Federal and State Principles and Requirements				
<u>Contractor</u> State or Local Govt. & Indian Tribal Govts.	<u>Cost Principles</u> OMB Circular A-87	<u>Federal Audit Requirements</u> OMB Circular A-133	<u>State Audit Requirements</u> SULCAG	<u>Grant Admin. Requirements</u> OMB Common Rule (Circular A-102)
Hospitals	45 CFR 74	OMB Circular A-133	SULCAG	OMB Common Rule or Circular A-110
College or University	OMB Circular A-21	OMB Circular A-133	SULCAG	OMB Circular A-110
Non-Profit Organization	OMB Circular A-122	OMB Circular A-133	SULCAG	OMB Circular A-110
For-Profit Organization	48 CFR 31	n/a	n/a	OMB Circular A-110
<u>Documents</u>	<u>Web Address</u>			
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			
SULCAG	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 (Circular A-102) 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.

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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

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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

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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

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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 its language in all of its 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 federal governmental department or agency (<http://epls.gov>). 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/excluded 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.).

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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

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\$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

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SPECIAL PROVISIONS

SECTION I: DEFINITIONS

- 1.1 **"CMS"** means the Centers for Medicare and Medicaid Services, the federal Medicaid agency, within the Department of Health and Human Services.
- 1.2 **"Covered Service"** means a service identified in Attachment C of this contract which the Health Plan has agreed to provide and pay for under the terms of this Contract.
- 1.3 **"Enrollee"** means any CHIP recipient who is currently enrolled with the Health Plan and:
- A. Who, at the time of enrollment resides within the geographical limits of the Health Plan's Service area;
 - B. Whose name appears on the Health Plan's Eligibility Transmission as a new, reinstated, or retroactive Enrollee; and
 - C. Who is accepted for enrollment by the Health Plan according to the conditions set forth in this Contract.
 - D. Where applicable, Enrollee means an individual, who has been terminated, or was previously enrolled on CHIP.
- 1.4 **"Health Plan"** as used in Attachments B, C, D, E, and F means the Offeror
- 1.5 **"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 the Health Plan or its contractors furnish to CHIP Enrollees.
- 1.6 **"External Quality Review Organization (EQRO)"** means an entity under contract with the DEPARTMENT to conduct an external quality review of the Health Plan in accordance with Federal regulations governing quality reviews.
- 1.7 **"Family Member"** means all individuals who are members of the same family living at home.
- 1.8 **"Grievance"** means an expression of dissatisfaction about any matter relating to CHIP coverage. 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.
- 1.9 **"Grievance Process"** means the Health Plan's process for handling

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grievances 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 notifications.

- 1.10 **“Member Services”** means a method of assisting Enrollees in understanding Health Plan policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and Enrollee complaints. The purpose of Member Services is to improve access to services and promote Enrollee satisfaction.
- 1.11 **“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.
- 1.12 **“Potential Enrollee”** means an individual, who may become an Enrollee in the CHIP Program.
- 1.13 **“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.
- 1.14 **“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 Health Plan 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.
- 1.15 **“Secretary”** means the Secretary of Health and Human Services.
- 1.16 **“State Eligibility Worker”** means a staff member of an agency of the State of Utah who receives applications, makes eligibility decisions, and manages the eligibility cases of Enrollees.
- 1.17 **“State Plan”** means the officially recognized statement describing the nature and scope of the Utah CHIP program as defined pursuant to Title XXI of the Social Security Act (42 CFR, 457.40(b))
- 1.18 **“Subcontract”** means any written agreement between the Health Plan and another party to fulfill the requirements of this Contract. However, such term

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does not include insurance purchased by the Health Plan to limit loss with respect to an individual Enrollee.

SECTION II: GENERAL INFORMATION

2.1 Program Overview: Children's Health Insurance Program (CHIP)

The Utah Department of Health (the DEPARTMENT) operates a Title XXI Children's Health Insurance Program (CHIP) for Utah residents eligible to participate in the program. Under this Agreement, the HEALTH PLAN will enroll and serve CHIP Enrollees in all counties of the State of Utah.

The DEPARTMENT's objectives for its managed care program include the following:

- A. To improve access to preventive services and primary care for Utah's CHIP population.
- B. To ensure that medically necessary services within the CHIP scope of coverage are provided to all Enrollees enrolled with Health Plans.
- C. To better integrate CHIP beneficiaries with the privately insured population through enrollment into managed care delivery systems serving these populations.
- D. To foster price competition in the delivery of health care services, thereby decreasing the rate of increase in CHIP health care expenditures.
- E. To ensure that quality, access, and cost effectiveness are incorporated into the delivery of CHIP services.

Utah's CHIP managed care program is under the administrative control of the DEPARTMENT, the state's designated Title XXI agency. The program also is overseen by the CMS through its regional office in Denver, Colorado and its central office in Baltimore, Maryland.

2.2 Service Area Definitions

Utah's CHIP program will operate throughout the State of Utah. All Enrollees will be enrolled in a contracted health plan. Notwithstanding the geographic coverage of the Health Plan's networks at the time of the Health Plan's proposal, the Health Plan agrees to have in place at the time the contract begins, a state-wide provider network and a state-wide

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hospital network.

2.3 Covered Populations and Non-covered Populations

A. Covered Populations

- i. Uninsured children under age 19 in families with incomes equal to or less than 200% of the Federal Poverty Level.
- ii. Underinsured children, children with limited coverage plans such as dental and vision, under age 19 in families with incomes equal to or less than 200% of the Federal Poverty Level.

B. Non-Covered Populations: Children with private insurance or who are covered by or qualify for Medicaid are ineligible for CHIP.

2.4 Contract Period

It is anticipated that the Contract will be for a three-year period with the possibility of two one-year extensions. Rates will be for the first year of the Contract. Annually, the Department and Health Plan may renegotiate rates during the Contract period.

SECTION III: HEALTH PLAN PARTICIPATION STANDARDS

3.1 Licensure

Participation in CHIP managed care is limited to organizations that are licensed by the Department of Insurance or are otherwise approved as a prepaid Health Plan pursuant to the Utah State Plan. The DEPARTMENT will not award contracts to any organizations prior to their becoming licensed or approved.

3.2 Operating Staff

The Health Plan must have sufficient operating staff to comply with all participation standards described in the Contract. At a minimum, the Health Plan must be able to identify qualified staff in the following areas:

- A. Executive management with clear oversight authority for all other functions.
- B. Medical Director's office

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- C. Accounting and Budgeting function
- D. Member Services function
- E. Provider Services function
- F. Medical Management function, including quality assurance and utilization review.
- G. Enrollee and Provider complaint and grievance resolution function.
- H. Management information system.

The Health Plan must plan for increased workload during periods of increased CHIP marketing and outreach.

The Health Plan and the DEPARTMENT agree to respond to communications from each other before the end of the next business day. The Health Plan and the DEPARTMENT agree to designate a backup contact person for those positions the other believes needs a backup.

3.3 Eligibility Determination

Eligibility determination for the Utah CHIP program will be performed by State Eligibility Workers.

3.4 Member Enrollment and Disenrollment

3.4.1 Enrollment Process

Applicants will discuss enrollment with a State Eligibility Worker and will be provided with information regarding the CHIP program, available CHIP benefits, Enrollee rights and responsibilities, and their Health Plan options. At the Enrollee's option, a choice of Health Plan will be made at the time of application.

3.4.2 Health Plan Selection

The DEPARTMENT shall offer potential Enrollees a choice among all health care plans available in that enrollment area. If a client fails to select a health plan, the DEPARTMENT may assign the client to a health plan.

3.4.3 Enrollment Period

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Each Enrollee shall be enrolled until the earliest of the following:

- A. the end of the Contract;
- B. the period of CHIP eligibility from the date of application;
- C. until a Plan change is made during an open plan switch period; or
- D. until such Enrollee is disenrolled.
 - i. If a CHIP Enrollee becomes eligible for Medicaid during the current month covered by CHIP or a month previously covered by CHIP, CHIP coverage will end at the end of the current month. For this month, CHIP will be the primary insurance and will continue paying claims according to this contract.
 - ii. If a CHIP Enrollee becomes eligible for private insurance during the same month or a month previously covered by CHIP, CHIP coverage will end the day prior to coverage with private insurance. The HEALTH PLAN will make a good faith effort to recover claims paid after the date coverage began with private insurance. The HEALTH PLAN will recover such claims according to industry standards. The Health Plan will use recovered claims to offset the total claims expenses.

Until the DEPARTMENT notifies the Health Plan an Enrollee is no longer CHIP eligible or is no longer enrolled with the Health Plan, the Health Plan may assume that the Enrollee continues to be enrolled. Generally, the enrollment period is for one year from the time of enrollment.

3.4.4 Identification Card

The Health Plan must issue an identification card to all Enrollees, except to retro-only enrollees, listing at a minimum:

- A. Children's Health Insurance Program (CHIP)
- B. Plan
 - i. Plan A covers Enrollees equal to or less than 100% of federal poverty level (FPL);
 - ii. Plan B covers Enrollees from 101-150% of FPL;
 - iii. Plan C covers Enrollees from 151-200% FPL; and

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- iv. Native American Enrollees.
- C. Name of Health Plan
- D. A toll-free number

The Health Plan must issue the identification card to new Enrollees within fifteen (15) business days (21 calendar days) after the DEPARTMENT notifies the Health Plan of the Enrollee's enrollment.

3.4.5 Health Plan Marketing (Including Informational Materials)

The Health Plan's marketing plans, procedures and materials must be accurate and correct, and may not mislead, confuse, or defraud either Enrollees or the DEPARTMENT. All CHIP marketing plans, procedures and materials must be reviewed and approved by the DEPARTMENT before implemented or released by the Health Plan. The DEPARTMENT shall notify the Health Plan of its approval or disapproval in writing of such materials within ten working days after receiving them unless the DEPARTMENT and the Health Plan agree to another time frame. Marketing materials are defined as materials in all mediums, including but not limited to Enrollee handbooks, brochures and leaflets, newspaper, magazine, radio, television, Internet, billboard and yellow pages advertisements, and presentation materials used by Health Plan representatives. It includes materials mailed to, distributed to, or aimed at Enrollees specifically, and any materials that mentions "CHIP" or "Title XXI." Marketing materials will not be approved if the DEPARTMENT determines that the materials are inaccurate or misleading or otherwise makes misrepresentations. Health education materials and newsletters not specifically related to CHIP Enrollees do not need to be approved by the DEPARTMENT.

Door-to-door solicitation by the Health Plan is prohibited.

3.4.5.1 Other Marketing Restrictions

(Reference: Social Security Act, section 1932 (d)(2))

- A. Service market.—The Health Plan shall distribute marketing materials to the entire service area of such entity covered under the contract under section [1903\(m\)](#) or section [1905\(t\)\(3\)](#) (of the Social Security Act).
- B. Prohibition of tie-ins.—The Health Plan, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in

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conjunction with the sale of any other insurance.

- C. Prohibiting marketing fraud.—The Health Plan shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.
- D. Prohibition of “cold-call” marketing.—The Health Plan shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment.

3.4.6 Member Services Function

- A. The Health Plan must operate a Member Services function during regular business hours. Ongoing training, as necessary, shall be provided by the Health Plan to ensure that Member Services staff is conversant in the Health Plan’s policies and procedures as they relate to Health Plan Enrollees. At a minimum, Member Services staff must be responsible for the following:
 - i. Explaining the Health Plan’s rules for obtaining services;
 - ii. Assisting Enrollees to select or change primary care providers;
 - iii. Fielding and responding to Enrollee questions and complaints and grievances.
- B. The Health Plan shall conduct ongoing assessment of its staff to determine staff members’ understanding of the Health Plan and its CHIP managed care policies and provide training, as needed.

3.4.7 Enrollee Handbook

- A. The Health Plan will produce an Enrollee handbook that is written at no greater than a sixth grade reading level and must be submitted to the DEPARTMENT for review and approval before distribution. Any changes to the Enrollee handbook must be submitted to the DEPARTMENT for review and approval before distribution. At a minimum, the Enrollee handbook must explain in clear terms the following information:
 - i. The scope of benefits provided by the Health Plan;

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- ii. 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 specialty care; and procedures for resolving Enrollee issues related to authorization of coverage or payment for services.
 - iii. Instructions on what to do in an emergency or urgent medical situation, including emergency numbers and what constitutes an emergency service;
 - iv. Information about immunizations and well-child visits;
 - v. Description of Enrollee cost-sharing requirements;
 - vi. Toll-free telephone number;
 - vii. Description of Member Services function;
 - viii. How to register a complaint or grievance;
- B. The Health Plan will use the electronic transmission from the DEPARTMENT to determine prevalent non-English languages. A language is prevalent when it is spoken by five percent or more of the Health Plan's enrolled population. The Health Plan will make available written material (e.g. Enrollee handbooks, educational newsletters) in prevalent non-English languages.
- C. The DEPARTMENT will notify the Health Plan in writing of its approval or disapproval within ten working days after receiving the Enrollee handbook unless the DEPARTMENT and the Health Plan agree to another time frame. If there are changes to the content of the material in the handbook, the Health Plan will update the Enrollee handbook and submit a draft to the DEPARTMENT for review and approval before distribution to its Enrollees.
- D. The Health Plan will periodically notify Enrollees, in writing, of changes to its plan such as changes to its policies or procedures either through a newsletter or other means. In addition, the Health Plan will annually notify all Enrollees in writing how to access emergency services and how to register a complaint or grievance.

3.4.8 New Enrollee Orientation

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The Health Plan will ensure that each Enrollee's family or guardian receives the Health Plan's Enrollee handbook within 10 working days after the Health Plan has received enrollment information. The Health Plan representative shall make a good faith effort, as evidenced in written records, to make an initial contact with the Enrollee within 10 working days after the Health Plan has been notified of the Enrollee's selection.

- A. The initial contact will be in person, by telephone, or, as a last result, in writing, and will ensure that the Enrollee understands and agrees to be bound by the Health Plan's rules or policies. The Health Plan 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. During the initial contact the Health Plan representative will provide to the Enrollee or potential Enrollee, at a minimum, the following:
 - i. Specific written or oral instructions on the use of Health Plan benefits or procedures;
 - ii. Information on the availability and accessibility of all covered benefits and services;
 - iii. Information on the right to file a grievance and how to file a grievance;
 - iv. Information on the right to terminate enrollment with the Health Plan.
 - v. Encouragement to make a medical appointment with a Health Plan provider.
 - vi. Encouragement to use well-child services and receive immunizations.
- B. The Health Plan shall take steps to identify Enrollees with special health care needs. When an Enrollee is identified as having special health care needs, such information will be given to appropriate Health Plan personnel to coordinate care. The Health Plan will not discriminate on the basis of health status or the need for health care services.

If the Health Plan representative cannot contact the Enrollee within 10 working days, or at all, the Health Plan representative will document efforts to contact the Enrollee.

3.4.9 Health Plan Enrollment

- A. Initial Enrollment

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The DEPARTMENT shall certify, and the Health Plan agrees to accept individuals who are eligible to be enrolled in this program:

- i. In the order in which they apply; and
- ii. Without restrictions unless authorized by the DEPARTMENT.

B. Annual Plan Switch Periods

For CHIP Enrollees, there will be an annual plan switch period when Enrollees can change their Health Plan selection. The DEPARTMENT will verify that the Enrollee is still eligible for the program.

3.4.10 Health Plan Non-Discrimination Requirements

Health Plans may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against an Enrollee on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition. No potential Enrollee shall be prescreened or selected by either the DEPARTMENT or the Health Plan for enrollment on the basis of pre-existing health problems.

3.4.11 Individual Choice of Health Plan

Each CHIP Enrollee can be enrolled or disenrolled in a Health Plan, independent of the enrollment or disenrollment of any other children in the family.

3.4.12 Notification to Health Plans of Eligibility and Enrollment

- A. The Health Plan must be able to accept files in the ANSI standard through the Utah Health Information Network (UHIN) standard. The DEPARTMENT will provide to the Health Plan an Eligibility Transmission which is an electronic file that includes eligibility information for CHIP Enrollees. The transmission will generally occur on a daily basis. The DEPARTMENT certifies eligibility information contained in the Eligibility Transmission. Eligibility transmissions include new and reinstated Enrollees, terminated Enrollees, retro-only Enrollees, and Enrollees whose eligibility information results in a change to a critical field. This electronic file is in accordance with the Utah Health Information Network (UHIN) standard. Appearance of an individual's name on the Eligibility Transmission, other than a terminated Enrollee, certifies that such individual is enrolled in the program and qualifies for CHIP assistance

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under Title XXI and that the DEPARTMENT agrees to pay premiums for such Enrollee.

- i. New Enrollees are enrolled in the Health Plan until otherwise specified; these Enrollees will not appear on future transmissions unless there is a change in a critical field.
 - ii. Critical fields are coverage dates, Enrollee's name, date of birth, date of death, sex, social security number, case information, address, telephone number, payment code, and coordination of benefits.
 - iii. Terminated Enrollees are those who are no longer eligible for CHIP or who were disenrolled from the Health Plan.
 - iv. Reinstated individuals are those who were enrolled for the previous month and closed at the end of the previous month. These individuals are eligible retroactively to the beginning of the current month.
 - v. Retro-only Enrollees are those who were enrollees in CHIP for a period of time in the past but are not currently enrolled.
- B. The DEPARTMENT will provide the Health Plan a monthly Eligibility Synchronization Transmission which is an electronic file that includes all CHIP Enrollees at the time of the report. The purpose of the report is to regularly synchronize eligibility between the DEPARTMENT and Health Plan. On a monthly basis, the Health Plan will compare the Synchronization Transmission to their eligibility system and will identify and resolve discrepancies so that eligibility on the Health Plan's system matches the DEPARTMENT Eligibility Synchronization Transmission. This electronic file is in accordance with the Utah Health Information Network (UHIN) standard. Appearance of an Enrollee's name on the Eligibility Synchronization Transmission certifies that Enrollee is enrolled in the program and qualifies for CHIP assistance under Title XXI and that the DEPARTMENT agrees to pay premiums for such Enrollee.
- C. If an Enrollee is a patient in an inpatient hospital setting on the date that his or her name appears as a terminated Enrollee on the Health Plan Eligibility Transmission or he or she is otherwise disenrolled, the Health Plan will remain financially responsible for such care until discharge.

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3.4.13 Information to Enrollees and Potential Enrollees

(Reference: Social Security Act, Section 1932 (A)(5))

- A. The Health Plan shall provide all enrollment notices and informational and instructional materials in a manner and form which may be easily understood by enrollees and potential enrollees.
- B. Information to enrollees and potential enrollees.—The Health Plan shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:
 - i. Providers.—The identity, locations, qualifications, and availability of health care providers that participate with the organization.
 - ii. Enrollee rights and responsibilities.—The rights and responsibilities of enrollees.
 - iii. Grievance and appeal procedures.—The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.
 - iv. Information on covered items and services.—All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization.

3.4.14 Disenrollment by Enrollee

Enrollees have the right to disenroll with cause or during the annual plan switch period. The disenrollment will be effective once the Health Plan has been notified and the disenrollment is indicated on the Eligibility Transmission.

3.4.15 Disenrollment by the Health Plan

- A. The Health Plan may not terminate enrollment because of an adverse change in the Enrollee's health or because of the Enrollee's utilization of services.
- B. The Health Plan may initiate disenrollment of any Enrollee's participation in the program upon one or more of the following reasons:

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- i. For reasons specifically identified in the Health Plan's approved Enrollee handbook.
- ii. When the Enrollee ceases to be eligible for medical assistance under the CHIP (Title XXI) State Plan, as determined by the DEPARTMENT.
- iii. Upon termination of the Health Plan's Contract with the DEPARTMENT.
- iv. Confinement of the Enrollee in an institution when confinement is not a benefit of CHIP.
- v. Violation of enrollment requirements developed by the Health Plan and approved by the DEPARTMENT but only after the Health Plan and/or the Enrollee has exhausted the applicable grievance procedure.
- vi. When the Health Plan determines that the Enrollee has other valid health insurance coverage.
- vii. To initiate disenrollment of an Enrollee's participation in the program, the Health Plan will provide the DEPARTMENT with documentation justifying the proposed disenrollment. The DEPARTMENT will approve or deny the disenrollment request by email or 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 constitutes approval of such disenrollment requests.

If the DEPARTMENT approves the Health Plan's disenrollment request, the Health Plan will give the Enrollee thirty (30) days written notice of the proposed disenrollment, and shall notify the Enrollee of his or her opportunity to invoke the internal grievance procedure and appeals process for a fair hearing. The Health Plan shall give a copy of the written notice to the DEPARTMENT at the time the notice is sent to the Enrollee.

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

3.4.16 Enrollee Transition Between Health Plans

When CHIP Enrollees are transferred between Health Plans, the relinquishing Health Plan provider shall submit, upon request of the new Health Plan provider, any critical medical information about the transferred Enrollee prior to the transition. This includes, but is not limited to, whether the Enrollee is

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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). For services other than inpatient, home health, and medical equipment, if prior authorization has been given for a procedure and an Enrollee transfers enrollment between Health Plans prior to the procedure, the receiving Health Plan shall be bound by the relinquishing Health Plan's prior authorization until the receiving Health Plan has evaluated the medical necessity of the service, and a new plan of care is established with the Health plan.

3.5 Covered Services

The Health Plan is responsible for furnishing medically necessary services to CHIP Enrollees. These services may be provided directly or through arrangements with sub-contractors. Attachment C contains a detailed description of the covered services, limitations, exclusions, and cost sharing provisions.

Except as otherwise provided for cases of emergency services, Health Plans have the exclusive right and responsibility to arrange for all benefits listed in Attachment C. The Health Plan is responsible for payment for all covered emergency services 24 hours a day and 7 days a week, whether the service is provided in or out of the Health Plan's service area.

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 health plan of any such changes and their effective date.

3.5.1 Clarification on Certain Covered Services

3.5.1.1 Mental Health Services Coordination

When an Enrollee presents with a possible mental health condition to his or her primary care physician within the Health Plan, it is the responsibility of the primary care physician to determine whether the Enrollee should be referred to a psychologist, pediatric specialist, psychiatrist, neurologist, or other specialist.

Mental health conditions may be handled by the primary care provider and referred to the mental health provider when more specialized services are

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required for the Enrollee.

3.5.1.2 Maternity Stays

- A. The Health Plan shall ensure that coverage is provided to a mother who is an Enrollee and her newborn child for a minimum of 48 hours of inpatient care following a normal vaginal delivery, and a minimum of 96 hours of inpatient care following a caesarean section, without requiring the attending provider to obtain authorization from the Health Plan in order to keep a mother and her newborn child in the inpatient setting for such period of time.
- B. Notwithstanding the prior paragraph, the Health Plan shall not be required to provide coverage for post-delivery inpatient care for a mother who is an Enrollee and her newborn child during such period of time if (1) a decision to discharge the mother and her newborn child prior to the expiration of such period is made by the attending provider in consultation with the mother; and (2) the Health Plan provides coverage for timely post-delivery follow-up care.
- C. Post-delivery care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in (1) the home, a provider's office, a hospital, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under regulations promulgated by the Secretary of Health and Human Services, (including a birthing center or an intermediate care facility).
- D. "Timely post-delivery care" means health care that is provided (1) following the discharge of a mother and her newborn child from the inpatient setting; and (2) in a manner that meets the health needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs within the 24 to 72 hour period immediately following discharge.

3.5.1.3 Organ Transplantations

All organ transplantation services are the responsibility of the Health Plan for all Enrollees in accordance with the criteria set forth in State administrative rules (Rule R414-10A of the Utah Administrative Code). The DEPARTMENT's criteria will be provided to the Health Plan. The following transplantations are covered:

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Kidney, Kidney/Pancreas, Liver, Cornea, Bone Marrow, Stem Cell, Heart and Lung.

- A. CHIP Enrollees who have applied for organ transplantations will undergo a psycho social assessment to assist in determining the Enrollees'/families' mental stability, commitment and potential to be compliant with the treatment and follow-up care that will go on for the rest of the Enrollee's life. This psycho social evaluation is covered under the CHIP scope of benefits.
- B. When the Health Plan arranges for the transplantation to be performed out of state, the Health Plan is responsible for coverage of food, lodging, transportation and airfare expenses for the Enrollee and attendant. The Health Plan will follow, at a minimum, the DEPARTMENT'S criteria for coverage of food, lodging, transportation, and airfare expenses found in the Utah Medicaid Provider's Manual.

3.5.1.4 Diabetes Education

Under orders of a health care professional with prescribing authority, the Health Plan shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an Enrollee:

- A. has recently been diagnosed with diabetes; or
- B. 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
- C. is determined by the health care professional to require re-education or refresher training.

3.5.2 Emergency Services

(Reference: Social Security Act, section 1932 (b)(2))

- A. The Health Plan shall provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and will comply with guidelines established under section [1852\(d\)\(2\)](#) of the Social Security Act (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of title XVIII.

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- B. Emergency services defined. In subparagraph (A), the term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—
- (i) are furnished by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and
 - (ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).
- C. Emergency medical condition defined.—In subparagraph (B)(ii), the term “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—
- (i) 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,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part.

3.6 Non-Covered Services

A non-covered service or item is one that is not covered under Health Plan contracts, or includes special features or characteristics that do not meet the medical necessity criteria for amount, duration, and scope as put forth in the Utah State Plan. When the Enrollee desires a service that is not covered, the Health Plan provider may bill a CHIP Enrollee only when the following conditions are met:

- A. The Health Plan has an established policy for billing all patients for services not covered by a third party (The charge cannot be billed only to CHIP Enrollees).
- B. The Health Plan has informed Enrollees of its policy and the services and items that are non-covered and has included this information in the Enrollee handbook.
- C. The Enrollee has been advised by the Health Plan provider who will be

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rendering the service prior to providing the service that it is a non-covered service and that it is not covered by the Health Plan, and that the Enrollee will be personally responsible for making payment.

The Enrollee's CHIP card may not be "held" by the Health Plan or the Health Plan provider as guarantee of payment by the Enrollees, nor may any other restrictions be placed upon the Enrollee.

3.7 Coordination With Other Entities

The Health Plan will coordinate with other entities by obtaining or seeking and providing access to a coordinated, comprehensive and continuous array of needed services through coordination with other appropriate entities.

The Health Plan will inform the DEPARTMENT of Enrollees with other health insurance coverage.

3.8 Access to Service

Health Plans will provide services which are accessible to Enrollees and appropriate in terms of timeliness, amount, duration, and scope. Health Plans may not restrict a health care provider's ability to advise and counsel Enrollees about medically necessary treatment options.

3.8.1 Physical Disabilities

Health Plans will minimize, with a goal to eliminate, Enrollees' access problems due to geographic, cultural and language barriers, and physical disabilities. Health Plans will provide assistance to Enrollees who have communication impediments or impairments to facilitate proper diagnosis and treatment. Health Plans will accommodate Enrollees with physical and other disabilities in accordance with the American Disabilities Act of 1990 (ADA), as amended. If the Health Plan's facilities are not accessible to Enrollees with physical disabilities, the Health Plan must provide services in other accessible locations.

3.8.2 Interpretive Services

Health Plans shall provide interpretive services for languages on an as needed basis at no cost to the Enrollees. These requirements shall extend to both in-person and telephone communications to ensure that Enrollees are able to communicate with the Health Plan and Health Plan providers and receive coverage benefits. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. Family members may

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be used as interpreters at the Enrollee's request only after Enrollee has been notified that professional interpreters are available at no cost. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

3.8.3 Geographic Distribution of Providers

A. The health plan's provider network will be state-wide in coverage and have sufficient capacity to serve current enrollees plus room for expansion

B. Primary Care Providers

The Health Plan must have at least two primary care providers within 40 miles of each enrollee's residence. Exceptions to this policy must be only for rural areas where this is a general shortage of primary care providers.

3.8.4 Appointments & Waiting Times

The Health Plan shall request that physicians comply with the following benchmarks:

Waiting Time for Appointments

A. Primary Care Providers:

- i. within 21 days for routine, non-urgent appointments
- ii. within 60 days for school physicals
- iii. within 2 days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)

B. Specialists:

- i. within 30 days for non-urgent care
- ii. within 2 days for urgent, symptomatic, but not life-threatening care (care that can be provided in a doctor's office)

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These standards 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 three weeks.

3.8.5 Choice of Primary Care Physician

The Health Plan must offer to the Enrollee, to the extent possible and appropriate, a choice in the selection of his or her primary care provider from among those who are available to provide, coordinate and authorize the Enrollee's care.

3.8.6 Benefits Received Outside the Plan Paid for by the Health Plan

The Health Plan shall not be required to pay for any benefits, defined in Attachment C, which the Enrollee receives from sources outside the Plan (out-of-plan provider), not arranged for and not authorized by the Health Plan, except as follows:

- A. Cases of emergency.
- B. Court-ordered services that are a benefit defined in Attachment C, and these services should be coordinated with the Health Plan when possible, including tuberculosis treatment.
- C. Cases where the Enrollee demonstrates that such services are within the scope of benefits, were medically necessary, and were unavailable from the Health Plan.
- D. Services received from date of application to effective date of enrollment.
- E. Services received after effective date of enrollment but before a Health Plan orientation. Payment for these services is described in Attachment F.

3.8.7 Program Benefits Provided by the Division of Community and Family Health Services within the DEPARTMENT.

For Enrollees who qualify for special services offered by or through the Division of Community and Family Health Services (DCFHS), the Health Plan agrees to reimburse DCFHS at the standard CHIP rate for one outpatient team evaluation and one follow-up visit when the Enrollee becomes CHIP eligible and selects the Health Plan as its provider. The Health Plan agrees to waive any prior authorization requirement for one outpatient team evaluation and one follow-up visit. The services provided in the outpatient team evaluation and follow-up visit

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for which the Health Plan must reimburse DCFHS are limited to the services that the Health Plan is otherwise obligated to provide under this Contract.

If the Health Plan desires a more detailed agreement for additional services to be provided by or through DCFHS, the Health Plan may subcontract with DCFHS.

3.8.8 DEPARTMENT's Responsibility for Payment of CHIP Benefits

Except as described in Attachment F, "Rates and Rate-Related Terms," the DEPARTMENT shall not be required to pay for any benefits available under Attachment C which the Enrollee received from any sources outside the Health Plan.

3.8.9 Subcontracts

- A. Any covered service may be subcontracted by the Health Plan. The subcontracts must be in writing and must include the general requirements of any contract that are appropriate to the service or activity including confidentiality requirements and must assure that all duties of the Health Plan under the Contract are performed. No subcontract terminates the legal responsibility of the Health Plan to the DEPARTMENT to assure that all activities under contract are carried out. The Health Plan must make model subcontracts available to the DEPARTMENT for review upon request.
- B. All subcontracts and agreements will include a provision stating that if either party (the sub-contractor or Health Plan) wishes to terminate the subcontract or agreement, whichever party initiates the termination must give the other party written notice of termination at least 30 calendar days prior to the effective termination date. The Health Plan must notify the DEPARTMENT of the termination whether the Health Plan either initiates termination or receives the notice of termination from the sub-contractor.
- C. All subcontracts will contain assurances that the quality of care standards of the Health Plan will be met by the sub-contractor. The Health Plan remains responsible for the monitoring of the quality of care provided by the sub-contractor.
- D. All Health Plan providers, both physician and non-physician, shall be aware of and comply with the quality assurance obligations of the Health Plan. All subcontracts with providers shall include requirements binding providers to quality assurance standards.

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- E. Health Plans must pay their participating providers and sub-contractors on a timely basis consistent with the claims payment schedule stated below, unless the health care provider and the Health Plan agree to an alternate payment schedule.
 - i. 90 percent (90%) of “clean” claims must be paid within thirty (30) days of receipt, and
 - ii. 99 percent (99%) of “clean” claims must be paid within ninety (90) days of receipt.
 - iii. “Clean” claims are claims that can be processed without obtaining additional information from the provider of the service or from a third party.

3.8.10 Enrollees with Special Health Care Needs

The Health Plan must ensure there is access to all services to meet the health needs of Enrollees with special health care needs in accordance with the Covered Services, Limitations and Exclusions in Attachment C. Enrollees 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 children, generally. Such health conditions limit physical functioning, activities of daily living, or social role in comparison to age peers.

- A. The Health Plan must identify Enrollees with special health care needs using a process at the initial contact made by the Health Plan representative to educate the Enrollee and must offer the Enrollee care coordination or case management services. Care coordination services are services to assist the Enrollee in obtaining needed medical services from the Health Plan or another entity if the medical service is not covered under the Contract.
- B. The Health Plan must have a mechanism to inform care givers and, when appropriate, Enrollees with special health care needs about primary care providers who have training in caring for such Enrollees (and providers who can verify diagnoses, develop treatment plans, provide services, etc.) so that an informed selection of a provider can be made. If the Health Plan restricts the number of referrals to specialists, the Health Plan shall not penalize those providers who make such referrals for such Enrollees.

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- C. The Health Plan must have primary care providers with skills and experience to meet the needs of Enrollees with special health care needs. The Health Plan must allow an appropriate specialist to be the PCP but only if the specialist has the skills to monitor the Enrollees' preventive and primary care services.
- D. The Health Plan must ensure there is access to appropriate specialty providers to provide evaluation and treatment services for Enrollees with special health care needs. If the Health Plan does not employ or contract with a specialty provider to treat a special health care condition at the time the Enrollee needs the specialist's services, the Health Plan must have a process to allow the Enrollee to request services from a qualified specialist who may not be affiliated with the Health Plan. The process for requesting specialist's care must be clearly described by the Health Plan and explained to each CHIP Enrollee upon enrollment.
- E. If a Potential Enrollee is receiving hospice services at the time of enrollment in the Health Plan, or if an Enrollee is already in the Health Plan and has less than six months to live, the Enrollee must be offered hospice services or the continuation of hospice services if he or she is already receiving such services.

3.8.11 Enrollee Transition Between Health Plans

- A. Inpatient Hospital
 - i. When an Enrollee is in an inpatient hospital setting and selects another Health Plan any time prior to discharge from the hospital, the original Health Plan is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e. physician, etc. The new Health Plan in which the Enrollee is enrolled at the time of discharge from the hospital is financially responsible for the remainder of the month when the Enrollee was discharged.
 - ii. If a potential Enrollee is in an inpatient hospital setting, has not previously been covered under CHIP, enrolls in CHIP, and selects the Health Plan anytime prior to discharge from the hospital, the Health Plan is financially responsible for the entire hospital stay including all services related to the hospital stay, i.e., physician, etc.
 - iii. Enrollees who are in an inpatient hospital setting at the time the Health Plan terminates its Contract and who have enrolled with another Health Plan are the responsibility of the original Health Plan until the discharge of the Enrollee from the hospital.

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B. Specialized Medical Equipment

- C. When specialized medical equipment is ordered for an Enrollee enrolled in a Health Plan, and the Enrollee changes to another Health Plan before receiving the equipment, the Health Plan that ordered the equipment is responsible for payment.
- D. Specialized medical equipment includes specialized wheelchairs or attachments, prosthesis, and other equipment designed or modified for an Enrollee. Any attachments to the equipment, replacements, or new equipment are the responsibility of the Health Plan in which the Enrollee is enrolled at the time the equipment is ordered.

3.8.12 Protection of Enrollee-Provider Communications

The health plan (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in Section 1921 (b)(3) of the Social Security Act) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

3.9 Grievance & Appeals

The Health Plan will maintain a system for reviewing and adjudicating complaints and grievances by CHIP Enrollees and providers under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance. The grievance process includes a formal hearing before an administrative law judge under the Utah Administrative Procedures Act. The Health Plan shall submit such grievance plans and procedures to the DEPARTMENT for approval prior to instituting or changing such plans and procedures. Such plans and procedures shall provide for expeditious resolution of complaints and grievances by the Health Plan's personnel who have authority to correct problems. The DEPARTMENT shall be consulted prior to any final determination of the grievance. At a minimum, the plans and procedures must address the following:

- A. Definitions of complaints and grievances;
- B. Details of how, when, where and with whom an Enrollee or provider may

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file a grievance;

- C. Assurances of the participation of individuals with authority to take corrective action;
- D. Responsibilities of the various components and staff of the organization
- E. Description of the process for timely review, prompt resolution of complaints and grievances;
- F. Details of an appeal process; and
- G. Provision stating that during the pendency of any grievance procedure or an appeal of such grievances, the Enrollee will remain enrolled except as otherwise stated in the Contract.

When an Enrollee or provider has exhausted the Health Plan's grievance process and a final decision has been made, the Health Plan must provide written notification of the outcome of the grievance and explain in clear terms a detailed reason for the denial. The health plan must explain in writing to the Enrollee the process of requesting a Utah Department of Health State Fair Hearing.

3.10 Other Requirements

3.10.1 Fraud and Abuse Requirements

The Health Plan agrees to abide by Federal and/or State fraud and abuse requirements including, but not limited to, the following:

- A. Refer in writing to the DEPARTMENT all detected incidents of potential fraud or abuse on the part of providers of services to Enrollees.
- B. Refer in writing to the DEPARTMENT all detected incidents of patient fraud or abuse involving services provided which are paid for in whole, or in part, by the DEPARTMENT.
- C. Refer in writing to the DEPARTMENT the names and CHIP ID numbers of those Enrollees that the Health Plan suspects of inappropriate utilization of services, and the nature of the suspected inappropriate utilization.
- D. The Health Plan may not employ or subcontract with any sanctioned provider. Providers whose licenses have been suspended or revoked by

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the Department of Professional Licensing are to be removed from the Health Plan.

- E. The Health Plan shall determine whether current providers, potential providers, and individuals with an ownership or control interest in provider entities are excluded individuals or entities. The Health Plan shall make this determination by doing a monthly search of the Medicare Exclusion Database or the List of Excluded Individuals/ Entities (created by the Office of the Inspector General) for excluded providers. Before accepting new providers, the Health Plan shall ensure that potential providers and individuals with ownership or control interest in provider entities are not excluded individuals or entities by using the same resources listed above. To the best of the Health Plan's knowledge, the Health Plan must attest that none of the entities listed below are involved with the Health Plan, its contractors, or subcontractors:
- i. Entities in which a person who is an officer, director, partner, agent, or managing employee of the entity (e.g., a general manager, business manager, administrator) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity and has been debarred, suspended, or excluded, or convicted of the following crimes:
 - a. Any criminal offense related to the delivery of a CHIP item or service;
 - b. patient abuse;
 - c. fraud;
 - d. obstruction of an investigation; or
 - e. offenses related to controlled substances.
 - ii. Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed in subsection i above. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following:
 - a. the administration, management, or provision of medical services;
 - b. the establishment of policies pertaining to the administration, management or provision of medical services; or

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- c. the provision of operational support for the administration, management, or provision of medical services.
- iii. Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in the Medicaid or Medicare program for the provision of health care, utilization review, medical social work or administration services.
- iv. If the Health Plan becomes aware that any entity listed above becomes involved with the Health Plan, prompt notice shall be given to the DEPARTMENT.
- v. If the Health Plan becomes aware that any entity listed above has become involved with the Health Plan, the Health Plan will take prompt action to remove such entity from the CHIP program.
- vi. The Health Plan will reimburse to the Department any payments made to excluded providers or entities.

3.10.1.1 Prohibitions against affiliations with individuals debarred by federal agencies

(Reference: Social Security Act, section 1932, (d)(1))

(A) The Health Plan may not knowingly—

(i) have a person described in subparagraph (B) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

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(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

3.10.2 Safeguarding Confidential Information on Enrollees

The Health Plan agrees that information about Enrollees is confidential information and agrees to safeguard all confidential information and conform to the requirements of applicable federal and state confidentiality requirements.

3.10.3 Provider Services Function

The Health Plan will operate a "Provider Services" function during regular business hours. At a minimum, Provider Services staff must be responsible for the following:

- A. Training, including ongoing training, network providers and subcontracting providers in CHIP rules and regulations that will enable providers to appropriately provide services to Enrollees;
- B. Assisting providers to verify whether an individual is enrolled with the Health Plan;
- C. Assisting providers with prior authorization and referral protocols;
- D. Assisting providers with claims payment procedures;
- E. Fielding and responding to provider questions and complaints and grievances.

3.10.4 Provider Incentive Plans

No specific payment can 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 individual Enrollee.

3.10.5 Contracting with Indian Health Services

The Health Plan shall contract with Indian Health Services to provide services to CHIP enrollees.

3.10.6 Contracting with Indian Health Care Providers (H.R. 1, Section 5006 (d))

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- A. If an Indian health care provider participates as a primary care provider in the health plan's network, Indian enrollees must be allowed to choose an Indian health care provider as the Indian's primary care provider.
- B. As a condition of receiving payment, the health plan must demonstrate that the number of Indian health care providers that are participating providers are sufficient to ensure timely access to covered services.
- C. As a condition of receiving payment, the health plan agrees to pay Indian health care providers whether network providers or not. Network Indian health care providers shall receive the negotiated rate. Out of network providers shall receive payment that is not less than what other non-Indian health care providers would receive.
- D. As a condition of receiving payment, the health plan agrees to make prompt payment to Indian health care providers.
- E. As a condition of receiving payment, the health plan agrees to pay an Indian health care provider that is a federally qualified health center (FQHC) but not a participating provider at the same rate as the health plan would a non-Indian health center that is a FQHC and also a participating provider.

3.10.7 Required Network Hospitals

The Health Plan's state-wide hospital network shall include but not be limited to the following hospitals:

(1) Primary Children's Medical Center, (2) Intermountain Medical Center, (3) McKay-Dee Medical Center, (4) Utah Valley Regional Medical Center, (5) Dixie Regional Medical Center, (6) Logan Regional Medical Center, (7) Gunnison Valley hospital, and (8) San Juan hospital.

3.10.8 Protecting enrollees against liability for payment.

(Reference: Social Security Act , section 1932 (b)(6))

The Health Plan shall provide in its subcontracts that an individual eligible for medical assistance under the State plan under this title who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

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(B) for services provided to the individual—

(i) in the event of the organization failing to receive payment from the State for such services; or

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

3.10.9 Antidiscrimination

(Reference: Social Security Act, section 1932 (B)(7))

The Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

3.10.10 Compliance with certain maternity and mental health requirements

(Reference: Social Security Act, section 1932 (B)(8))

The Health Plan shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

3.11 Payments

3.11.1 Premium Payments

A. On or before the 10th day of each month, the DEPARTMENT shall pay to the Health Plan the premiums due for each category shown for Enrollees in the Health Plan for that month as determined by the

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DEPARTMENT from the enrollment and reinstatement transmissions. Rates will be those rates agreed on by the Health Plan and the DEPARTMENT and are attached hereto as Attachment F.

- B. The Health Plan will receive premium payments for CHIP Enrollees beginning the month of the date of application. The Health Plan is responsible for claims payment (coverage) for CHIP Enrollees from the date of application.

3.11.2 Federally Qualified Health Center and Rural Health Clinic Payments

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

3.11.3 Vaccines For Children Payments

CHIP uses a federal program, Vaccines for Children to purchase vaccines at half price. The State Immunizations Office is contracted with CHIP to distribute these pre-paid vaccines to participating medical providers for use by CHIP enrollees. The Health Plan shall not reimburse providers for the cost of these pre-paid vaccines and shall not include pre-paid vaccine payment errors in paid claims data submitted to the Department.

3.12 Records, Reports, Audits, and Meetings

3.12.1 Reports

Reports are due on the dates listed. If the due date falls on a weekend or on a state holiday, the reports are due on the next business day.

- A. Health Plans must submit immunization data to the Department. Enrollee name, CHIP ID, type of immunization identified by procedure code, and date of immunization will be reported in accordance with the Encounter Data Technical Manual.
- B. 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):
 - i. A report of the total number of organ transplants by type of transplant.

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- ii. A summary of complaints and formal grievances, by type of complaint or grievance, received by the Health Plan under this Contract and actions taken to resolve such complaints and grievances.
 - iii. Summary information of corrective actions taken on physicians who have been identified by the Health Plan as exhibiting aberrant physician behavior and the names of physicians who have been removed from the Health Plan network due to quality concerns.
 - iv. Attachment E Report.
 - v. Claims detail supporting Attachment E figures. Beginning May 1, 2011, the May 1 Attachment E and supporting claims detail will be for the 12-month period January 1 to December 31.
 - vi. A report describing subcontractor claims processing times during the period. The report will provide the number of claims submitted, the number of clean claims submitted, the number of clean claims paid within 30 days, and the number of clean claims paid within 90 days. The report will also provide the percentage of clean claims paid within 30 days and the percentage of clean claims paid within 90 days.
- C. Annually, on November 1, the Health Plan will submit a report that identifies the Health Plan's internal quality assurance activities, results thereof, and corrective actions taken during the previous state fiscal year (July through June).
- D. The Health Plan is required to submit formally collected and audited HEDIS data to the DEPARTMENT. Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered during each calendar year and will be reported as set forth in State rule by the Office of Health Care Statistics or HEDIS measures will be calculated based on submitted encounter data by the DEPARTMENT. For example, calendar year 2009 HEDIS measures will be reported in 2010.
- E. The HEALTH PLAN will assign a staff member to attend an annual HMO Advisory Committee Meeting as convened by the Office of Health Data Analysis to discuss the CAHPS/HEDIS Review.
- F. When requested by the DEPARTMENT, the Health Plan will send Encounter data. Encounter data shall be due two weeks from the time of the request unless another time frame is agreed to by both parties in writing.

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- G. Due prior to site visits: The following documents are due on request prior to the DEPARTMENT'S site visit to the Health Plan unless the DEPARTMENT has already received documents that are in effect. The documents must show evidence of a well defined, organized program designed to improve Enrollee care and have a method of measuring over utilization and under utilization of services provided to Enrollees:
- i. the Health Plan's written plan for quality assurance; and
 - ii. the Health Plan's annual quality improvement work plan;
 - iii. the Health Plan's reports that identify over and under utilization of covered services and efforts put in place to resolve inappropriate over utilization and under utilization; and
 - iv. the Health Plan's process for identifying and correcting aberrant provider behavior.
- H. On a monthly basis, the Health Plan will submit to the DEPARTMENT an Income Statement for the prior month including but not limited to the following: enrollment totals, revenue, and paid medical and pharmacy costs. The due date for this report is the last day of the month. For example February's income statement will be due March 31.
- I. On a monthly basis, the Health Plan will submit to the DEPARTMENT a report describing the time it takes for enrollees to be sent their health plan ID cards. The report will detail the number of ID cards sent within the following time periods calculated in calendar days: 0-21 days; over 21 days; and not yet sent. It will also detail the overall average number of days. The number of days will be calculated starting the day the Health Plan receives enrollment information from the DEPARTMENT and ending the day the health plan sends the ID card. Reporting will occur in the second month after the Health Plan receives the enrollment information. For example, the report for enrollees whose enrollment information was received by the Health Plan in January would be reported in March to the DEPARTMENT. The due date for this report is the last day of the month.
- J. Any new reports/data requirements required by the DEPARTMENT will be mutually developed by the DEPARTMENT and the Health Plan.

3.12.2 Medical Records

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The Health Plan agrees that medical records are considered confidential information and agrees to follow Federal and State confidentiality requirements.

The Health Plan shall require that subcontracting providers make records available to the DEPARTMENT upon request and 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. Notwithstanding any other provision of this Contract to the contrary, medical records covering Enrollees shall remain the property of the Health Plan provider, and the Health Plan provider will respect each 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 the Health Plan. The Health Plan shall use and disclose information pertaining to individual Enrollees and prospective Enrollees only for purposes directly connected with the administration of the CHIP program.

3.12.3 Audits

- A. The DEPARTMENT and the Secretary of the Department of Health and Human Services including CMS shall have the right to audit and inspect any books and records of the Health Plan and its subcontractors pertaining to evaluating services performed or determinations of amounts payable under the Contract.
- B. The Health Plan shall make available to the DEPARTMENT all reasonable and related financial, statistical, clinical or other information needed for the determination of allowable costs to the CHIP program for "related party/home office" transactions as defined in CMS 15-1. These records are to be made available in Utah or the Health Plan must pay the increased cost (incremental travel, per diem, etc.) of auditing at the out-of-state location. The cost to the Health Plan shall include round-trip travel and two days per diem/lodging. Additional travel costs of the site audit shall be shared equally by the Health Plan and the DEPARTMENT.
- C. The Health Plan shall allow the DEPARTMENT and the Department of Health and Human Services including CMS to perform audits for identification and collection of management data, including Enrollee satisfaction data, quality of care data, patient outcome cost, and utilization data, which will include patient profiles, exception reports, etc. The Health Plan shall provide all data required by the DEPARTMENT or the independent quality review examiners in performance of these audits. Prior to beginning any audit, the DEPARTMENT shall give the Health Plan reasonable notice of audit, and the DEPARTMENT shall be

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responsible for costs of its auditors or representatives.

3.12.4 External Quality Review Organization

The DEPARTMENT may choose and pay for a qualified external quality review organization (EQRO) to review the quality, timeliness, and access to covered services provided by the Health Plan.

3.12.5 External Quality Review

The Health Plan agrees to support the external quality review.

The external quality reviews are conducted by the EQRO with the advice, assistance, and cooperation of a planning team composed of representatives from the Health Plan, the EQRO, and the DEPARTMENT with final approval by the DEPARTMENT.

- A. The Health Plan will designate an individual to serve as liaison with the EQRO for routine communication with the EQRO.
- B. The Health Plan will designate a minimum of two representatives (unless one individual can service both functions) to serve on the planning team for each focused study. Representatives will include a quality improvement representative and a data representative. The planning team is a joint collaborative forum between DEPARTMENT staff, the EQRO and the Health Plan. The role of the planning team is to participate in the process and completion of focused studies.
- C. The Health Plan 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 the external quality review. Any associated copying cost is the responsibility of the Health Plan. Enrollee information includes medical records, administrative data such as, but not limited to, enrollment information and claims, nurses' notes, medical logs, etc. of the Health Plan or its providers.
- D. The Health Plan 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. The Health Plan will provide data requests 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

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EQRO. Requests for extensions of these time frames will be reviewed and approved or disapproved by the DEPARTMENT on a case-by-case basis.

- F. The Health Plan will assure that the EQRO staff and consultants have adequate work space and access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.
- G. The Health Plan will assign appropriate personnel to assist the EQRO personnel during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.
- H. For information received from the EQRO, the Health Plan will comply with the Department of Health and Human Services regulations relating to confidentiality of data and information.

3.12.6 Quality Assurance and Utilization Management

The Quality Assurance and Utilization Management requirements and sanctions for Health Plans are outlined in Attachment D.

3.13 Termination of Contract

3.13.1 Automatic Termination

This Contract shall have an automatic termination date.

3.13.2 Termination for Failure to Agree Upon Rates

At least 60 days prior to the end of each contract year, the parties shall meet and negotiate in good faith the rates (Attachment F) applicable to the upcoming year. If the parties do not agree upon future rates by the end of the contract year, then either party may terminate the Contract for subsequent years by giving the other party written notice of termination and the termination will become effective 90 days after receipt of the written notice of termination.

3.13.3 Effect of Termination

Inasmuch as the Health Plan is paid on a monthly basis for each Enrollee, the Health Plan shall continue providing Covered Services required by this Contract until the following:

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- A. midnight of the last day of the calendar month in which the termination becomes effective; or
- B. If an Enrollee is a patient in an inpatient hospital setting during the month in which termination becomes effective, the Health Plan is responsible for the entire hospital stay including physician charges until discharge or thirty days following termination, whichever occurs first.

The Health Plan must promptly supply to the DEPARTMENT all information necessary for the reimbursement of any CHIP claims not paid by the Health Plan.

3.13.4 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 shall be deemed an assignment. Consent may be withheld in the DEPARTMENT'S sole and absolute discretion.

3.14 Miscellaneous Provisions

- A. 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 the Contract shall not be used as a guide to the interpretation or enforcement of this Contract or any provision hereof.
- B. 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 Health Plan nor shall any provision of this Contract be constructed to constitute a promise by the Health Plan to any Enrollee or potential Enrollee.
- C. The DEPARTMENT shall be responsible for the interpretation of all federal and state laws and regulations governing or in any way affecting this Contract. When interpretations are required, the Health Plan shall submit written requests to the DEPARTMENT. The DEPARTMENT shall retain full authority and responsibility for the administration of the CHIP program in accordance with the requirements of federal and state law. Adoption of rules by the DEPARTMENT, subsequent to this amendment, and which govern the CHIP program, shall be automatically incorporated into this Contract upon receipt by the Health Plan of written

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notice thereof.

3.15 Effect of General Provisions

If there is a conflict between these Special Provisions (Attachment B) or the General Provisions (Attachment A), then these Special Provisions shall control.

3.15.1 Dispute Resolution

In the event of a dispute arising out of this Agreement, the parties agree to submit to mediation by a mutually acceptable independent third party. If mediation fails to remedy the dispute, the parties agree to submit the matter to mandatory, binding arbitration.

3.16 Sanctions

A. Late deliverables

Late reports due under section 3.12.1 will be subject to the following late penalties:

All reports other than those in section H and I		Reports in sections H and I	
1-15 days late	\$0	1-15 days late	\$0
16-60 days late	\$2,500 per report	16-60 days late	\$500 per report
Over 60 days	\$5,000 per report	Over 60 days	\$1,000 per report

Penalties for late deliverables will have an annual limit of \$10,000 per report and \$50,000 for all reports (based on the contract year).

B. Sanctions for not meeting other contract standards of management

Penalties will be assessed for each occurrence where the Health Plan does not meet the following contract requirements:

1. The time limit for issuing ID cards. Monthly calculation. \$10 per card over 21 calendar days. Maximum of \$10,000 per month
2. Claims processing time standards for clean claims. Semi-annual calculation. (a) \$10,000 if below 85% for clean claims processed within 30 days; (b) \$10,000 if below 95% for clean

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claims processed within 90 days.

Total sanctions for not meeting the contract requirements in this paragraph B will be subject to a total penalty of no more than \$50,000 per contract year.

C. Intermediate Sanctions under Section 1932 of the Social Security Act

(Reference: Section 1932 (e) of the Social Security Act)

1. The Department may impose sanctions listed in subsection 2 against the Health Plan if the Health Plan:

(a) fails substantially to provide medically necessary items and services that are required (under law or this contract) to be provided to an enrollee covered under the contract;

(b) imposes charges on enrollees in excess of the charges permitted under the contract;

(c) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this title, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(d) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the Department under Title XIX or Title XXI; or

(II) to an enrollee, potential enrollee, or a health care provider under such title; or

(e) fails to comply with the applicable requirements of section [1903\(m\)\(2\)\(A\)\(x\)](#) (of the Social Security Act).

2. The following sanctions may be imposed if the Health plan is found by the Department to have performed any of the actions listed in subsection 1 above:

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- (a) The Department may permit individuals enrolled with the managed care entity to terminate enrollment without cause, and may notify such individuals of such right to terminate enrollment.
 - (b) The Department may suspend enrollment of all individuals under Title XIX or Title XXI of the Social Security Act after the date the Secretary or the Department notifies the Health Plan of a determination of a violation of any of the items in section 1 above or any of the requirements of section [1903\(m\)](#).
 - (c) The Department may impose civil money penalties of
 - a. \$15,000 for each violation of subsection 1, paragraphs (a), (c), (d) or (e).
 - b. Double the excess amount charged in violation of section 1 (b) (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).
3. Before imposing the sanctions listed in subsection 2, the State shall provide the Health Plan with notice and such other due process protections as the State may provide.

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**Covered Services, Limitations, Exclusions
and Co-Payment Requirements**

SECTION 1: Covered Services

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

The Health Plan is responsible to provide or arrange for all appropriate covered services on an emergency basis 24 hours each day, seven days a week. The Health Plan is responsible for payment for all covered emergency services furnished by providers that do not have arrangements with the Health Plan.

1.1 Hospital Services

A. Inpatient Hospital

Services furnished in a licensed, certified hospital.

B. Outpatient Hospital

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

C. Emergency Department Services

Emergency services provided to Enrollees in designated hospital emergency departments.

1.2 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

1.3 Vision Care

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

Services include:

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- A. Routine vision examinations.
- B. One exam every 12 months.

1.4 Lab and Radiology Services

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

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.

1.5 Physical Therapy/ Occupational Therapy

Treatment and services provided by a licensed physical or occupational therapist. A physician must authorize treatment and services for physical or occupational therapy. Coverage includes up to 20 visits total per policy year for physical and occupational therapy.

1.6 Chiropractic Services

This is not a covered benefit.

1.7 Hearing Services

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss. One exam every 12 months. Hearing aids are covered only to improve impairment due to a congenital defect.

1.8 Podiatry Services

Services provided by a licensed podiatrist.

1.9 End Stage Renal Disease - Dialysis

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

1.10 Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses and licensed practical nurses) in the Enrollee's home when the Enrollee is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified Home Health Agency.

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1.11 Speech Therapy

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

1.12 Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

1.13 Durable Medical Equipment and Supplies

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

1.14 Abortions and Sterilizations

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

1.15 Organ Transplants

The following transplantations are covered for all Enrollees: kidney, kidney/pancreas, liver, cornea, bone marrow, stem cell, heart and lung, unless amended under the provisions of the Health Plan contract.

1.16 Other Outside Medical Services

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

1.17 Transportation Services

Ambulance (ground and air) service for medical emergencies.

1.18 Preventive Services (Well-Child Care)

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

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

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The Health Plan agrees to educate and encourage compliance with the AAP periodicity schedules. These efforts will include education and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHIP Enrollees.

1.19 Family Planning Services

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services provided must include prior written consent of a minor's parent or legal guardian. All services must be provided in concert with Utah law.

The following family planning services are not covered:

- A. Norplant
- B. Infertility drugs
- C. In-vitro fertilization
- D. Genetic counseling

1.20 Pharmacy Services

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

Prospective drug utilization review at the point of sale and retrospective drug utilization review will be done by the health plan or its pharmacy benefit manager.

1.21 Mental Health

- A. Inpatient care (Residential treatment may be provided in lieu of inpatient care.)

If a CHIP Enrollee would be otherwise hospitalized for treatment of a mental illness or substance abuse, and

- 1. in lieu of hospitalization, a lower level of care can be used; then
- 2. the lower level of care may be substituted at a rate of one outpatient visit in lieu of each inpatient day, which would be otherwise required.

- B. Outpatient services/visits

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1.22 Medical and Surgical Services of a Dentist

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. 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 under certain conditions including, but not limited to, the following:

- A. Services to repair injuries or accidents to sound, natural teeth are covered under the Contract.
- B. When an Enrollee is treated in an emergency room for severe mouth or tooth pain, the services are covered under the Contract. The Health Plan will reimburse such emergency providers based on standard emergency use criteria or a triage fee per the Health Plan's provider contracts. If the emergency room physician determines that it is not an emergency and the Enrollee requires services at a lesser level, the provider should refer the Enrollee to a dentist for treatment. If the dental-related problem is serious enough for the Enrollee to be admitted to the hospital, the Health Plan is responsible for coverage of the inpatient hospital stay.
- C. The Health Plan is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw.
- D. Outpatient facility and anesthesia charges are payable under the medical plan. The dental charges are payable under the dental plan.

The Health Plan is not responsible for services that are usually considered dental such as fillings, pulling of teeth, treatment of abscess or infection when provided by a dentist in the office or pain relief ordered by the dentist and orthodontics.

1.23 High-Risk Prenatal Services

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

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 prenatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconception counseling and planned pregnancy are the best ways to assure successful pregnancy outcome, but this is often not possible. Provision of routine preconception counseling must be made available to those Enrollees who have

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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.

- B. Enrollees who are pregnant should be risk assessed for medical and psychosocial conditions, which may contribute to a poor birth outcome at their first prenatal visit, preferably in the first trimester. The patient who is determined not to be at high risk should be evaluated for change in risk status throughout her pregnancy. There are a number of complex systems to determine how to assess the risk of pregnancies. The State has developed a risk assessment tool available through the Division of Community and Family Health Services, which is available upon request.

The Department of Health recommends prenatal screening of every woman for hepatitis B surface antigen (HBsAg) to identify all those at high risk for transmitting the virus to their newborns. When an Enrollee is found to be HBsAg-positive, the Health Plan will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life.

The provider should identify two groups of patients. Group I patients may be cared for by the Health Plan obstetrician, in consultation with a specialized obstetrical provider or referred to a specialized obstetrical provider or full-time perinatologist for complete care and delivery. Group II patients must be referred to an obstetrical provider with specialized training, i.e., perinatology, and must be delivered in a facility with perinatology and neonatology providers.

The Health Plan provider should determine not only the training and experience of the appropriate provider for prenatal/delivery care for the mother and infant, but also the capability of the appropriate facility to deliver the care needed by a high risk prenatal Enrollee and her fetus/infant. Health Plan providers should also consider Enrollee residence when making referrals.

Group I conditions are listed below:

1. Two or more previous stillborns.
2. Two or more previous infant deaths.
3. Anemia, excluding iron deficiency.
4. Chronic hypertension.
5. Labile epilepsy.
6. Hepatitis and acute fatty liver.
7. Renal disease, excluding mild cystitis.
8. Thyroid disease, if labile.
9. Exposure to known teratogens during the first trimester.
10. Idiopathic intrauterine growth retardation.
11. Placenta previa.
12. Premature labor approximately 32 to 36 weeks gestation.
13. Rh sensitization and any other positive antibody screen that is clinically significant antibody.

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14. Severe preeclampsia.
15. Infants weighing between 1500 and 2500 grams.

Group II conditions requiring referral for care at one of the facilities listed below with Perinatologist and/or Neonatologist:

1. Two or more previous premature infants less than 1500 grams.
2. Severe active collagen vascular disease.
3. Heart disease (Class II or greater, American Heart Association).
4. Severe hemoglobinopathies.
5. Serious medical problems of metabolism, such as PKU, Diabetes mellitus, Class C and greater.
6. Any fetal or maternal conditions affecting the fetus which might require intensive care, such as:
 - Hydrops fetalis
 - Documented IUGR
 - Maternal drug addiction
7. Congenital anomalies, such as congenital heart disease, open neural tube defects.
8. Abdominal wall defects or diaphragmatic hernia.
9. Multiple gestations, except twins.
10. Severe pregnancy associated hypertensive disease including cardiac, hepatic, hematologic or renal dysfunction.
11. Pre-term labor less than 32 weeks' gestation, if medically necessary.
12. Premature ruptured membranes at less than 32 weeks' gestation, if medically necessary.

Facilities that can care for above conditions:

- LDS Hospital
- McKay Dee Hospital
- Ogden Regional Medical Center
- University of Utah Hospital
- Utah Valley Regional Medical Center
- Primary Children's Medical Center (newborn intensive care only)
- Any other facility that can demonstrate competence in caring for the above conditions.

1.24 Services for Children with Special Needs

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

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The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

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

- A. Comprehensive evaluation for the condition.
- B. Pediatric sub-specialty consultation and care appropriate to the condition.
- C. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.
- D. Durable medical equipment appropriate for the condition.
- E. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

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

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

- 1. Nervous System Defects such as
 - Spina Bifida*
 - Sacral Agenesis*
 - Hydrocephalus
- 2. Craniofacial Defects such as
 - Cleft Lip and Palate*
 - Treacher - Collins Syndrome
- 3. Complex Skeletal Defects such as
 - Arthrogryposis*
 - Osteogenesis Imperfecta*
 - Phocomelia*
- 4. Inborn Metabolic Disorders such as
 - Phenylketonuria*
 - Galactosemia*
- 5. Neuromotor Disabilities, such as
 - Cerebral palsy*
 - Muscular Dystrophy*
 - Complex Seizure Disorders

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6. Congenital Heart Defects
7. Genetic Disorders such as
Chromosome Disorders
Genetic Disorders
8. Chronic Illnesses such as
Cystic Fibrosis
Hemophilia
Rheumatoid Arthritis
Bronchopulmonary Dysplasia
Cancer
Diabetes
Nephritis
Immune Disorders
9. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

SECTION 2: Exclusions

2.1 Hospital Exclusions (Inpatient and Outpatient Services)

- A. Hospital charges in conjunction with ineligible surgical procedures or related complications.
- B. Charges for treatment programs for enuresis (bed wetting) or encopresis.
- C. Convenience items such as guest trays, cots, and telephone calls.
- D. Occupational therapy and recreational therapy.
- E. Whole blood, autologous (self) blood storage for future use.
- F. Hospital charges while on leave-of-absence.
- G. Charges incurred as an organ or tissue donor.
- H. Charges for custodial care
- I. Charges for nutritional counseling
- J. Charges for care, confinement, or services in a transitional living facility, community reintegration program, vocational rehabilitation, or services to re-train self care or activities of daily living.

2.2 Surgery Exclusions

- A. Breast reconstruction, augmentation, or implant; except initial restoration made necessary as a result of cancer surgery performed in the preceding five years.
- B. Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of cosmetic or non-covered breast surgery.
- C. Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications.
- D. Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.
- E. Cosmetic surgery.
- F. Assisted Reproductive Technologies (ART's) including but not limited to In vitro Fertilization, Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use.
- G. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.
- H. Charges incurred as an organ or tissue donor.
- I. Organ or tissue transplant (except cornea, kidney, kidney/pancreas, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).
- J. Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.
- K. Complications as a result of other non-covered or ineligible surgery.
- L. Lipectomy, abdominoplasty, pannulectomy.
- M. Repair of diastasis recti.
- N. Non-FDA approved, experimental, or investigational procedures, drugs, and

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- devices.
- O. Charges for the treatment of weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.
 - P. Orthodontic treatment or expansion appliance in conjunction with jaw surgery.
 - Q. Chin implant, genioplasty or horizontal symphyseal osteotomy.
 - R. Unbundling or fragmentation of surgical codes.
 - S. Rhinoplasty, except as a result of accidental injury in the preceding five years.
 - T. Laser assisted uvulopalotoplasty (LAUP).
 - U. Additional surgical fees are not eligible when a laser is used.
 - V. Anesthesia charges in conjunction with ineligible surgery.
 - W. Anesthesia administered by the primary surgeon.
 - X. Monitored anesthesia care or on-call time for consultant.

2.3 **Physician Services Exclusions**

- A. Eyeglasses and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).
- B. Examinations made in connection with a hearing aid.
- C. Hormone injections or pellet implants (an allowance up to \$300 may be approved for injections when oral medication cannot be used). Office visits in conjunction with hormone injections are not covered.
- D. Charges for weight loss or in conjunction with weight loss programs.
- E. Charges for medical hospital visits the same day of following a surgical procedure.
- F. Charges for office visits in conjunction with allergy injection.
- G. Health screening or services to rule out familial diseases or conditions without manifest symptoms.
- H. Genetic counseling and testing except prenatal amniocentesis or chronic villi sampling for high-risk pregnancy.
- I. Charges for nutritional counseling or analysis.
- J. Charges for any injection when the material used is not identified.
- K. Hypnotherapy or biofeedback.
- L. Physical therapy primarily for maintenance care.
- M. Injectable vitamins or their administration.
- N. Experimental, investigational, or unproven medical practices.
- O. Vision therapy.
- P. Tobacco abuse.
- Q. Take-home medications from a provider's office.
- R. Treatment therapies for developmental delay or child developmental programs.
- S. Sublingual antigens.
- T. Rolfing or massage therapy.
- U. Hair transplants or other treatment for hair loss or restoration.
- V. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not

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- necessarily all, ineligible services for the treatment of TMJ/TMD, or myofacial pain.
- W. Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
 - X. Charges for prolotherapy or chelation therapy.
 - Y. Office calls in conjunction with repetitive therapeutic injections.
 - Z. Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.
 - AA. Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
 - BB. Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
 - CC. Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
 - DD. Charges for sublingual or colorimetric testing.
 - EE. Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
 - FF. Charges for pre-natal classes.
 - GG. Charges for the treatment of weak, strained, flat, or unstable feet; visits in connection with orthotics; palliative care or metatarsalgia or bunions; treatment for corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

2.4 **Lab and X-Ray Exclusions**

- A. Charges in connection with weight loss programs.
- B. Health screening or services to rule out familial diseases or conditions without manifest symptoms.
- C. Genetic screening except prenatal amniocentesis or chronic villi sampling.
- D. Charges incurred as an organ or tissue donor.
- E. Charges for sublingual or colorimetric testing.
- F. Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.
- G. Charges for hair analysis, trace elements, or dental filling toxicity.
- H. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluation.
- I. Routine drug screening.
- J. Routine HIV/AIDS testing.
- K. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

2.5 **Ambulance Exclusions**

- A. Charges for common or private aviation services.
- B. Services for the convenience of the patient or family.

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- A. Nursing or aide services which are requested for the client's convenience or the convenience of the client's family, (i.e., bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter) which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not payable. This exclusion applies regardless of whether services were recommended by a provider.
- B. Private duty nursing.
- C. Home health aide.
- D. Custodial care.
- E. Respite care.
- F. Travel or transportation expenses, escort services, or food services.
- G. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.

2.7 Mental Health and Substance Abuse Exclusions

- A. Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.
- B. Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
- C. Office calls in conjunction with repetitive therapeutic injections.
- D. Charges in conjunction with wilderness programs.
- E. Inpatient charges for behavior modification, enuresis, or encopresis.
- F. Psychological evaluations for legal purposes such as custodial rights, etc.
- G. Occupational or recreational therapy.
- H. Hospital charges while on leave of absence.

2.8 Durable Medical Equipment Exclusions

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

- A. Routine maintenance and care, cleaning solutions, batteries, tires, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.
- B. Maintenance, warranty, or service contracts.
- C. Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.
- D. Air conditioning.
- E. Home physical therapy kits.
- F. Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.

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- G. Air filtration units, vaporizers, humidifiers.
- H. Heating lamps or pads.
- I. Charges for a continuous hypothermia machine, cold therapy, or ice packs.
- J. Lift or contour chairs, vibrating chairs, or adjustable beds.
- K. Dialysis equipment.
- L. Orthotics, arch supports, shoe inserts or wedges, etc.
- M. Orthopedic or correctiveshoes. (Attachment of a brace or crossbar is eligible).
- N. Hearing aids (except as indicated under Covered Services).
- O. Adaptive devices used to assist with activities of daily living, vocational or life skills.
- P. Communicative equipment or devices, systems, or components.
- Q. Computerized assistive devices; communicative boards, etc.
- R. Breast pumps.
- S. Vitamins, minerals, food supplements, special infant formulas, or homeopathic medicine.
- T. Blood pressure monitors.
- U. Wrist alarms for diabetics.
- V. Enuresis alarm systems.
- W. Spinal pelvic stabilizers.
- X. Orthopedic braces solely for sports activities.
- Y. More than one breast prosthesis for each affected breast following surgery for breast cancer.
- Z. More than one lens for each affected eye following corneal transplant surgery.
- AA. More than two pair of support hose for a medical diagnosis per policy year.
- BB. Computer systems or components.
- CC. Environmental control devices, i.e., light switches, telephones, etc.
- DD. Replacement of lost, damaged, or stolen DME or prosthetics.
- EE. Eye glasses/contact lenses

2.9 **Pharmacy Exclusions**

The fact that a provider may prescribe, order, recommend, or approve a prescription drug, service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition.

- A. Drugs that are not medically necessary for condition.
- B. Experimental or investigational drugs.
- C. Anorexiant/diet aids (with the exception of Dexedrine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age 18).
- D. Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.
- E. Any drug not FDA approved.
- F. Therapeutic devices or appliances.
- G. Diagnostic agents.
- H. Prescriptions that an eligible person is entitled to receive from any governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Compensation or employers liability laws.

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- I. Medications taken while in an institution that operates on its premises a facility for dispensing pharmaceuticals.
- J. Any drug used for cosmetic purposes.
- K. Drugs used by a second party.
- L. Compounded drugs (a procedure that alters the FDA approved form of a legend drug.)
- M. Replacement prescriptions resulting from loss, theft or breakage.
- N. Delivery or shipping charges.
- O. Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
- P. Vitamins, minerals, food supplements, or homeopathic medicine.
- Q. Mother's milk or special infant formulas.
- R. Anabolic steroids (used for muscle building).
- S. Norplant and infertility drugs.

2.10 Family Planning and Prenatal Services Exclusions

- A. Norplant
- B. Infertility drugs
- C. In-vitro fertilization
- D. Genetic counseling.
- E. Charges for unproven medical practices or care, treatment or drugs, which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.

2.11 General Exclusions

- A. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP.
- B. Charges for educational material, literature or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illnesses such as diabetes.
- C. Charges for services primarily for convenience, contentment or other non-therapeutic purpose.
- D. Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
- E. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
- F. Charges which the insured is not, in the absence of coverage, legally obligated to pay.
- G. Charges for services, treatments or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
- H. Charges for services, treatments or supplies received as a result of an act of war occurring when the insured is covered by CHIP.
- I. Charges for any services received as a result of an industrial (on the job) injury or

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illness, any portion of which is payable under workman's compensation or employer's liability laws.

- J. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
- K. Charges made for completion or submission of insurance forms.
- L. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.
- M. Shipping, handling, or finance charges.
- N. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.
- O. Charges for expenses in connection with appointments scheduled and not kept.
- P. Charges for telephone calls or consultations.

SECTION 3: Co-Payment Requirements for Enrollees equal to and less than 100% of the Federal Poverty Level**(PLAN A)****3.1 Hospital Services** (inpatient, outpatient, and emergency department)

\$50 co-payment for inpatient hospital services

Plan pays 100% for surgeon and anesthesiologist services

For all other hospital services

\$3 co-payment per visit

3.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits.

\$3 co-payment per visit

No co-payment for well-baby care, well-child care and immunizations

20 visit per plan year limit on physical/ occupational therapy

Chiropractic visits are not covered

3.3 Laboratory and X-Ray Services

For laboratory services \$350 and under (of allowable charges): No co-payment

For laboratory services above \$350 (of allowable charges): \$3 co-payment

For X-ray services \$350 and under (of allowable charges): No co-payment

For X-ray services above \$350 (of allowable charges): \$3 co-payment

3.4 Prescription Drugs

For Rx \$50 and under (of allowable charges): \$1 co-payment per prescription if on the approved list

For Rx over \$50 (of allowable charges): \$3 co-payment per prescription if on the approved list

Plan pays 95% (of allowable charges) per prescription if not on the approved list

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3.5 Vision Screening Services

\$3 co-payment, limit of one exam every 12 months

3.6 Hearing Screening Services

\$3 co-payment, limit of one exam every 12 months

3.7 Durable Medical Equipment and Supplies

\$3 co-payment per month

3.8 Mental Health Services

3.8.1 Inpatient Care:

\$50 co-payment

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

3.8.2 Outpatient Care:

\$3 co-payment per visit

3.9 Ambulance - Ground and Air

Plan pays 95%

3.10 Home Health and Hospice Care

\$3 co-payment

3.11 Pre-existing Condition Waiting Period

No waiting period

3.12 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the DEPARTMENT. Upon request, the Health Plan will provide the DEPARTMENT with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the DEPARTMENT, the Health Plan will switch the family to a no out-of-pocket payment (exempt) option and will reimburse the family for any excess amount paid above 5%.

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NOTE: The allowed amount is (1) the contract rate that the Health Plan has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

**SECTION 4: Co-Insurance and Co-Payment Requirements for CHIP Enrollees
from 101-150% of the Federal Poverty Level****(PLAN B)****4.1 Hospital Services** (inpatient, outpatient and emergency department)

\$150 co-payment, after deductible for allowable inpatient hospital services

Plan pays 95%, after deductible for ambulatory surgical and outpatient hospital services

Plan pays 95% for surgeon and anesthesiologist services

\$10 co-payment for non-emergency use of emergency room

For all other hospital services

\$5 co-payment per visit

4.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

\$5 co-payment per visit

No co-payment for well-baby care, well-child care and immunizations

20 visit per plan year limit on physical/ occupational therapy

Chiropractic visits are not covered

4.3 Laboratory and X-Ray Services

For laboratory services \$350 and under (of allowable charges):

For laboratory services above \$350 (of allowable charges):

No co-payment

Co-insurance, 5% of
allowed amount after
deductible

For X-ray services \$350 and under (of allowable charges):

For X-ray services above \$350 (of allowable charges):

No co-payment

Co-insurance, 5% of
allowed amount after
deductible

4.4 Prescription Drugs

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For generic drugs on an approved list: \$5 co-payment per prescription

For all other drugs: Co-insurance, 5% of allowed amount

4.5 Vision Screening Services

\$5 co-payment, limit of one exam every 12 months.

4.6 Hearing Screening Services

\$5 co-payment, limit of one exam every 12 months.

4.7 Durable Medical Equipment and Supplies

Co-insurance, 5% of allowed amount after deductible

4.8 Mental Health Services**4.8.1 Inpatient Care:**

\$150 co-payment, after deductible

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

4.8.2 Outpatient Care:

\$5 co-payment per visit

4.9 Ambulance - Ground and Air

Co-insurance, 5% of allowed amount after deductible

4.10 Home Health and Hospice Care

Co-insurance, 5% of allowed amount after deductible

4.11 Deductible

Plan B enrollees are required to pay \$40 per family per year.

4.12 Pre-existing Condition Waiting Period

No waiting period

4.13 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

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If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the DEPARTMENT. Upon request, the Health Plan will provide the DEPARTMENT with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the DEPARTMENT, the Health Plan will switch the family to a no out-of-pocket payment (exempt) option and will reimburse the family for any excess amount paid above 5%.

NOTE: The allowed amount is (1) the contract rate that the Health Plan has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

**SECTION 5: Co-Insurance and Co-Payment Requirements for CHIP Enrollees
above 150% of the Federal Poverty Level****(PLAN C)****5.1 Hospital Services** (inpatient, outpatient and emergency department)

Co-insurance, 20% of allowed amount after deductible, for inpatient, outpatient, and ambulatory surgical services

Plan pays 80% for surgeon and anesthesiologist services

\$100 co-payment for each participating emergency department visit

\$200 co-payment for each non-participating emergency department visit

5.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

For physician and physical therapy visits: \$20 co-payment per visit

For all other outpatient office visits: \$30 co-payment per visit

No co-payment for well-baby care, well-child care and immunizations

20 visit per plan year limit on physical/ occupational therapy

Chiropractic visits are not covered

5.3 Laboratory and X-Ray Services

For laboratory services \$350 and under (of allowable charges):

No co-payment

For laboratory services above \$350 (of allowable charges):

Co-insurance, 20% of allowed amount, after deductible

For X-ray services \$350 and under (of allowable charges):

No co-payment

For X-ray services above \$350 (of allowable charges):

Co-insurance, 20% of allowed amount, after deductible

5.4 Prescription Drugs

For generic drugs on an approved list:

\$15 co-payment per prescription

For brand name drugs on an approved list:

Co-insurance, 25% of allowed amount

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For drugs not on an approved list:

Co-insurance, 50% of allowed amount

5.5 Vision Screening Services

\$20 co-payment, limit of one exam every 12 months

5.6 Hearing Screening Services

\$20 co-payment, limit of one exam every 12 months

5.7 Durable Medical Equipment and Supplies

Co-insurance, 20% of allowed amount after deductible

5.8 Mental Health Services**5.8.1 Inpatient Care:**

Co-insurance, 20% of allowed amount after deductible

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

5.8.2 Outpatient Care:

\$30 co-payment per visit

5.9 Ambulance - Ground and Air

Co-insurance, 20% of allowed amount after deductible

5.10 Home Health and Hospice Care

Co-insurance, 20% of allowed amount after deductible

5.11 Deductible

Plan C enrollees are required to pay \$500 per person / \$1,500 per family.

5.12 Pre-existing Condition Waiting Period

No waiting period

5.13 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

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If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the DEPARTMENT. Upon request, the Health Plan will provide the DEPARTMENT with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the DEPARTMENT, the Health Plan will switch the family to a no out-of-pocket payment (exempt) option and will reimburse the family for any excess amount paid above 5%.

NOTE: The allowed amount is (1) the contract rate that the Health Plan has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

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2009 CHIP Medical RFP**SECTION 6: Requirements for CHIP Native American Policy****6.1 Hospital Services** (inpatient, outpatient and emergency department)

No co-payment, plan pays 100%

Plan pays 100% for surgeon, anesthesiologist, ambulatory surgical, outpatient hospital, and hospital inpatient physician visits

6.2 Outpatient Office Visits or Urgent Care Center Visits

This includes physician, physician-related, physical and occupational therapy, urgent care, speech therapy, and podiatry visits.

No co-payment, plan pays 100%

No co-payment for immunizations and well child exams

20 visit per plan year limit on physical/ occupational therapy

Chiropractic visits are not covered

6.3 Laboratory and X-Ray Services

Plan pays 100%

6.4 Prescription Drugs

No co-pay for prescriptions

6.5 Vision Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

6.6 Hearing Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

6.7 Durable Medical Equipment and Supplies

Plan pays 100%

6.8 Mental Health Services**6.8.1 Inpatient Care:**

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Plan pays 100%

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

6.8.2 Outpatient Care:

Plan pays 100%

6.9 Ambulance - Ground and Air

Plan pays 100%

6.10 Home Health and Hospice Care

Plan pays 100%

6.11 Pre-existing Condition Waiting Period

No waiting period

6.12 Out-of-Pocket Maximum

Not applicable. There are not out-of-pocket expenses for Native Americans.

NOTE: The allowed amount is (1) the contract rate that the Health Plan has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.

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SECTION 7: Balance Billing

7.1 Balance Billing

No claim for payment, except for co-payments, deductibles, and co-insurance, will be made by the Health Plan or Health Plan provider from the Enrollee for a service covered under the CHIP contract.

The Health Plan and Health Plan provider will not balance bill the Enrollee. The Health Plan provider will consider the reimbursement from the Health Plan plus co-payments, deductibles, and/or co-insurance as payment in full.

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QUALITY ASSURANCE AND UTILIZATION MANAGEMENT

1. Quality of Care

The Health Plan shall establish a written quality assurance plan, an annual quality improvement work plan, and a plan for utilization management for covered services. All plans should show evidence of a well-defined, organized program designed to improve Enrollee care, to monitor over utilization and under utilization, and to identify and correct aberrant provider behavior. Prior to the effective date of the Contract, the plans must be reviewed by the DEPARTMENT. Together the plans must:

- A. Show systematic surveillance and assessment of all modes of delivery by appropriate health professionals;
- B. Show mechanisms and/or designation of individuals with specific responsibility to resolve identified problems;
- C. Provide for monitoring to assure that resolution is achieved and maintained with documentary evidence of same;
- D. Require use of written, clinically sound criteria to enhance Enrollee services and assure sound clinical performance by health care deliveries;
- E. Result in identification of important Enrollee service problems or potential problems including utilization of service patterns by provider and recipient;
- F. Monitor the effectiveness of the Enrollee grievance process.

2. Internal Monitoring

In order to assess medical necessity, appropriateness, quality of care, and timeliness of service, the Health Plan must monitor services to all CHIP Enrollees in accordance with the Health Plan's written quality assurance plans.

- A. The Health Plan must provide for an internal quality assurance plan that:
 - i. Is consistent with the utilization control requirement of part 456 of 42 CFR;
 - ii. Provides for review by appropriate health professionals of the process followed in providing health services;
 - iii. Provides for systematic data collection of performance and patient results;

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- iv. Provides for interpretation of this data to the practitioners; and
- v. Provides for making needed changes.
- B. Provision of high-quality health care services must be demonstrated by:
 - i. Adequate and appropriate diagnostic procedures;
 - ii. Treatment necessary and relevant to the working diagnosis;
 - iii. Appropriate consultation(s);
 - iv. Patient compliance with treatment;
 - v. Continuity of care with adequate transfer of information between health care providers;
 - vi. Appropriate, accurate, and complete Enrollee records;
 - vii. Patient satisfaction;
 - viii. Accessibility and availability of services including emergency services;
 - ix. Patient instruction in self-care, prevention and the use of medications and therapies;
 - x. The utilization of the least invasive and most cost-effective resources when possible;
 - xi. The use of ancillary services consistent with patients' needs; and
 - xii. Annual Enrollee satisfaction surveys will be conducted by the DEPARTMENT.

3. Objectives of Quality Assurance Monitoring

The objective of the quality assurance monitoring process is to ensure compliance to state and federal policies, rules and regulations; adherence to community standards; and integrity of CHIP payments made for medical services provided to Enrollees under the Health Plan. To achieve that objective:

- A. The Health Plan will report all cases of program abuse or suspected abusive or fraudulent behavior by either providers or recipients.
- B. The Health Plan will take appropriate, effective and coordinated action on all such information.

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- C. The Health Plan will:
- i. Make reasonable efforts, pursuant to the Health Plan's standard procedures, to correct the behavior of providers or recipients violating program regulations or exhibiting inappropriate program utilization;
 - ii. Report to the DEPARTMENT, in writing, any providers or recipients who fail to correct aberrant practices and continue to abuse the program;
 - iii. Ensure that funds do not continue to be disbursed in the presence of evidence indicating such practices; and
 - iv. Attempt to recover any funds improperly disbursed, as a result of such practices.

4. The DEPARTMENT's Quality Assurance Monitoring Plan

The DEPARTMENT shall review the Health Plan for compliance to standards defined in the DEPARTMENT's HMO Quality Assurance Monitoring Plan. This plan will be made available upon request.

5. Corrective Action

In the event that the DEPARTMENT discovers that the Health Plan is not performing as required under the terms of this Contract, the DEPARTMENT shall specify in writing all areas of alleged non-performance. The Health Plan shall respond in writing within 20 calendar days as to how it will remedy the non-performance or why it believes the allegations of non-performance are incorrect. If this response does not resolve the matter, the parties must promptly meet face-to-face to attempt to resolve all issues.

The Health Plan will in good faith implement corrective action as agreed upon with the DEPARTMENT when quality assurance monitoring, including but not limited to, site reviews, Health Plan documentation reviews, data analysis, medical audits, or complaints/grievances demonstrate the need for such corrective action. In addition, if the parties agree that the Health Plan has not provided services in accordance with the Contract or within expected professional standards, the DEPARTMENT will request, in writing, that the Health Plan correct deficiencies or identified problems by developing a corrective action plan.

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COST AND UTILIZATION REPORTING FORMS AND DEFINITIONS

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Note: FPL means Federal Poverty Level

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2009 CHIP Medical RFPTable 1
CHIP EnrollmentPERIOD COVERED:
PERIOD PAID:

	<u>0-100%</u> <u>FPL</u>	<u>101-150%</u> <u>FPL</u>	<u>151-200%</u> <u>FPL</u>	<u>TOTAL</u>
July				
August				
September				
October				
November				
December				
January				
February				
March				
April				
May				
June				

TOTAL CHIP ENROLLEES FY _____

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Table 2
Revenue & Cost Data
(Round to nearest dollar except for cost per Enrollee month)

Provider Name: _____

Reporting Period: _____

Period Paid (Cut-off Date): _____

			0-100% FPL	101-150% FPL	151-200% FPL	CHIP TOTALS
		REVENUES				
1		Premiums	\$	\$	\$	\$
2	=1	TOTAL REVENUES	\$	\$	\$	\$

		MEDICAL COSTS				
		Hospital Services				
3		Inpatient hospital	\$	\$	\$	\$
4		Outpatient hospital				
5		Emergency services				
		Physician Services				
6		Primary Care services	\$	\$	\$	\$
7		Specialty Care services				
		Vision Care				
8		Optometric services	\$	\$	\$	\$
9		Laboratory Services				
10		Radiology Services				
11		Physical Therapy				
12		Speech and Hearing Services				
13		Podiatry Services				
14		End Stage Renal Disease				
15		Home Health Services				
16		Hospice Services				
17		Medical Supplies				

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		MEDICAL COSTS (cont.)	0-100% FPL	101-150% FPL	151-200% FPL	CHIP TOTALS
18		Abortions & Sterilizations	\$	\$	\$	\$
19		Mental Health				
20		Organ Transplants				
21		Other Medical Services				
22		Chiropractic				
23		Transportation Services				
24		Pharmacy Services Net of Discount				
24a		Gross Pharmacy Services				
24b		Discount on Pharmacy Services				
24c		Manufacturer Rebates				
25		Dental Services (if applicable)				
26		Other				
27		IBNR				
28	3 thru 27	TOTAL MEDICAL COSTS	\$	\$	\$	\$

ADMINISTRATION COSTS

29		Administration - Advertising	\$	\$	\$	\$
30		Home Office Cost Allocation				
31		Utilization				
32		Administration –Other				
33	29 thru 32	TOTAL ADMIN. COSTS	\$	\$	\$	\$

34	2 -28 -33	NET INCOME (LOSS)	\$	\$	\$	\$
----	------------------	--------------------------	----	----	----	----

35		ENROLLEE MONTHS	#	#	#	#
36	28 ÷ 35	MED. COST/ ENROLLEE MO.	\$	\$	\$	\$

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37		Number of Deliveries	#	#	#	#
----	--	----------------------	---	---	---	---

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MEDICAL SERVICES REVENUE AND COST DEFINITIONS
FOR TABLE 2

I. REVENUES (Report all revenues paid or payable at the cut-off date indicated on the form.)

- A. Premiums. Report premium payments paid or payable by the DEPARTMENT.
- B. Total Revenue. Total line 1.

II. MEDICAL COSTS

Medical costs will include all medical costs incurred during the period being reported and paid any time before the cutoff date.

- C. Inpatient Hospital. Costs incurred in providing inpatient hospital services to Enrollees confined to a hospital.
- D. Outpatient Hospital. Costs incurred in providing outpatient hospital services to Enrollees, not including services provided in the emergency department.
- E. Emergency Department Services. Costs incurred in providing outpatient hospital emergency room services to Enrollees.
- F. Primary Care Physician Services. All costs incurred 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 payment, fringe benefits, travel and office supplies.
- G. Specialty Care Physician Services. All costs incurred as a result of providing specialty 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.
- H. 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.
- I. Laboratory Services. Costs incurred as a result of providing pathological tests or services 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.
- J. Radiology Services. Costs incurred in providing x-ray services, including x-ray payroll expenses, any capitation and/or contract payments, fee-for-services payments, and occupancy overhead costs. Excluded are costs associated with a hospital visit.

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- K. Physical 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 therapy services.
- L. Speech & 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.
- M. 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.
- N. End Stage Renal Disease. Costs incurred in providing renal dialysis (ESRD) services to Enrollees.
- O. 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.
- P. Hospice Services. Expenses related to home care, general inpatient care for patients suffering terminal illness, and inpatient respite care for caregivers of patients suffering terminal illness.
- Q. Medical Supplies. This cost center contains fee-for-service cost for outside acquisition of medical requisites, special appliances as prescribed by a Health Plan physician or provider.
- R. Abortions & Sterilizations. Medical and hospital costs incurred in providing abortions and sterilizations.
- S. Mental Health. Medical, hospital and alternative costs incurred in providing treatment for mental health and substance abuse.
- T. Organ Transplants. Medical and hospital costs incurred in providing transplants.
- U. Other Medical Services. Costs for specialized testing and outpatient surgical centers ordered by the Health Plan.
- V. Chiropractic. Costs incurred in providing chiropractic services.
- W. Transportation Services. Costs incurred in providing ambulance (ground and air) services.
- X. Pharmacy Services. Costs net of pharmacy discount incurred in providing pharmacy services. Costs are not net of rebates.
 - a. Gross Pharmacy costs before discount.
 - b. Pharmacy discount
 - c. Manufacturer rebates
- Y. Dental Services. Costs incurred in providing dental services. *Not applicable unless dental is covered in the Contract.*
- Z. Other. Report costs not otherwise reported.

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AA. IBNR. An actuarially certified estimate of costs incurred but not reported during the current period.

BB. TOTAL MEDICAL COSTS. Total lines 3 through 27.

III. ADMINISTRATION

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, CHIP 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.

CC. Administration – Advertising.

DD. Home Office Cost Allocation

EE. 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.

FF. Administration – Other

GG. TOTAL ADMINISTRATION COSTS. Total lines 29 through 32.

IV. NET INCOME

HH. NET INCOME (LOSS). Item 2 minus item 28 minus item 33.

V. OTHER

II. Enrollee Months. Total Enrollee months for period of time being reported.

JJ. MEDICAL COST PER ENROLLEE MONTH. Item 28 divided by item 35

KK. Number of Deliveries. Total number of deliveries when the delivery occurred at 24 weeks or later.

Attachment E
2009 CHIP Medical RFPTABLE 3
Utilization Data

Provider Name: _____
 Reporting Period: _____
 Period Paid (Cut-off Date): _____

		0 - 100% FPL	101 - 150% FPL	151 - 200% FPL	CHIP TOTAL
MEDICAL SERVICES					
	Hospital Services				
1	General Days				
2	Discharges				
3	Outpatient Visits				
4	Emergency Department Visits				
	Physician Services				
5	Primary Care Services				
6	Specialty Care Services				
	Vision Care				
7	Optometric Services				
8	Laboratory Procedures				
9	Radiology Procedures				
10	Physical Therapy Services				
11	Speech and Hearing Services				
12	Podiatry Services				
13	ESRD Services				
14	Home Health Visits				
15	Hospice Days				
16	Medical Supplies				
17	Abortions and Sterilization Procedures				
	Mental Health Services				
18	Inpatient Hospital Services				
19	Alternative Inpatient Services				
20	Services & Procedures by M/H Professional				
21	Organ Transplants				
22	Other Outside Medical Services				
23	Chiropractic Services				
24	Transportation Trips				
25	Pharmacy Prescriptions				
26	Dental Visits (if applicable)				

Attachment E
2009 CHIP Medical RFPMEDICAL 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 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 services and procedures defined by CPT 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. Vision Care - Optometric Services. Number of optometric services and procedures performed by an optometrist.
8. Laboratory (Pathology) Procedures. Number of procedures defined by CPT codes under the Pathology and Laboratory section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.
9. Radiology Procedures. Number of procedures defined by CPT codes under the Radiology section. Excluded are services performed in conjunction with a hospital outpatient or emergency department visit.
10. Physical Therapy Services. Physical therapy refers to physical therapy services and procedures performed by a physician or physical therapist.
11. Speech and Hearing Services. Number of services and procedures.
12. Podiatry Services. Number of services and procedures.
13. End Stage Renal Disease (ESRD) Services – Dialysis. Number of ESRD procedures provided upon referral.
14. Home Health Services. Number of home health visits, such as skilled nursing and personal care aide visits.
15. Hospice Days. Number of days hospice care is provided, including respite care.

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16. Medical Supplies. Durable medical equipment such as wheelchairs, hearing aids, etc., and non-durable supplies such as oxygen.
17. Abortions and Sterilization Procedures. Number of procedures performed.
18. Mental Health Inpatient Hospital Services. Days of mental health inpatient hospital services.
19. Mental Health Alternative Inpatient Services. Days of mental health alternative inpatient services.
20. Services & Procedures by Mental Health Professional. Number of services and procedures defined by CPT codes provided by a psychiatrist, psychologist, clinical social worker, or other mental health professional.
21. Number of organ transplants.
22. Other Outside Medical Services. Specialized testing and outpatient surgical services ordered by Health Plan.
23. Chiropractic Services. Number of services and/or procedures performed.
24. Transportation Trips. Number of ambulance trips.
25. Pharmacy Prescriptions. Number of prescriptions.
26. Dental Services. The number of services and procedures based on American Dental Association (ADA) codes performed. *Do not report unless dental is covered under contract.*

Attachment F
2009 CHIP Medical RFP

RATES AND RELATED PROVISIONS

1. Premium Rates

To be determined.

2. Contract Year

Tentatively, January 1, 2010 to December 31, 2011

3. 100 % Risk Contract

This contract is a 100% risk contract for the Health Plan with no stop loss or savings/ loss sharing provisions. The Department shall pay the Health Plan the premium per member per month as described in section 1. The Health Plan shall bear complete responsibility and risk for all expenditures related to this contract, including but not limited to medical, pharmacy, administration, and any other costs. Accordingly, all savings or losses that result from the difference between premium reimbursements and expenditures shall be retained by the Health Plan.

Attachment G - Hospital Groups

Instructions

1. For both hospital groups, mark all hospitals with which the Offeror is contracted or has a letter of intent to contract.

Hospital Group 1

- ☐ 1 Bear River Valley Hospital
- ☐ 2 Brigham City Community Hospital
- ☐ 3 **Logan Regional Hospital (REQUIRED)**
- ☐ 4 **McKay-Dee Medical Center (REQUIRED)**
- ☐ 5 Alta View Hospital
- ☐ 6 **Intermountain Medical Center (REQUIRED)**
- ☐ 7 LDS Hospital
- ☐ 8 **Primary Children's Medical Center (REQUIRED)**
- ☐ 9 The Orthopedic Specialty Hospital
- ☐ 10 American Fork Hospital
- ☐ 11 Orem Community Hospital
- ☐ 12 **Utah Valley Regional Medical Center (REQUIRED)**
- ☐ 13 Heber Valley Medical Center
- ☐ 14 Delta Community Medical Center
- ☐ 15 Fillmore Community Medical Center
- ☐ 16 Sanpete Valley Hospital
- ☐ 17 Sevier Valley Hospital
- ☐ 18 **Dixie Regional Medical Center (REQUIRED)**

Hospital Group 2

- ☐ 1 Cache Valley Specialty Hospital
- ☐ 2 Ogden Regional Medical Center
- ☐ 3 Davis Hospital and Medical Center
- ☐ 4 Lakeview Hospital
- ☐ 5 Jordan Valley Hospital
- ☐ 6 Pioneer Valley Hospital
- ☐ 7 Salt Lake regional Medical Center
- ☐ 8 St. Mark's Hospital
- ☐ 9 University of Utah
- ☐ 10 Mountain West Medical Center
- ☐ 11 Mountain View Hospital
- ☐ 12 Timpanogos Regional Hospital
- ☐ 13 Uintah Basin Medical Center
- ☐ 14 Ashley Valley Medical Center
- ☐ 15 Central Valley Medical Center
- ☐ 16 **Gunnison Valley Hospital (REQUIRED)**
- ☐ 17 Beaver Valley Hospital
- ☐ 18 Milford Valley Memorial Hospital
- ☐ 19 Castleview Hospital
- ☐ 20 Garfield Memorial Hospital
- ☐ 21 Allen Memorial Hospital
- ☐ 22 Valley View Medical Center
- ☐ 23 Kane County Hospital
- ☐ 24 **San Juan Hospital (REQUIRED)**

Attachment H

Local Health Department	County
Bear River District Health Department	BOX ELDER
Bear River District Health Department	CACHE
Bear River District Health Department	RICH
Central Utah District Health Department	JUAB
Central Utah District Health Department	MILLARD
Central Utah District Health Department	PIUTE
Central Utah District Health Department	SANPETE
Central Utah District Health Department	SEVIER
Central Utah District Health Department	WAYNE
Davis County Health Department	DAVIS
Salt Lake Valley Health Department	SALT LAKE
Southeastern District Health Department	CARBON
Southeastern District Health Department	EMERY
Southeastern District Health Department	GRAND
Southeastern District Health Department	SAN JUAN
Southwest District Health Department	BEAVER
Southwest District Health Department	GARFIELD
Southwest District Health Department	IRON
Southwest District Health Department	KANE
Southwest District Health Department	WASHINGTON
Summit County Health Department	SUMMIT
Tooele County Health Department	TOOELE
TriCounty Health Department	DAGGETT
TriCounty Health Department	DUCHESNE
TriCounty Health Department	UINTAH
Utah County Health Department	UTAH
Wasatch county Health Department	WASATCH
Weber-Morgan Health Department	MORGAN
Weber-Morgan Health Department	WEBER

Attachment I Cost Proposal Form

Give one bid (PMPM) to provide all medically necessary services as described in *Attachment C, Covered Services, Limitations, Exclusions and Co-Payment Requirements*.

The contract resulting from this RFP will be a 100% risk contract for the Health Plan with no stop loss or savings/ loss sharing provisions. The Health Plan will bear complete responsibility and risk for all expenditures related to this contract, including but not limited to medical, pharmacy, administration, and any other costs. Accordingly, all savings or losses that result from the difference between premium reimbursements and expenditures will be retained by the Health Plan.

PMPM \$ _____

(Any deviation from this format may result in disqualification of proposal)

Attachment J

RFP Evaluation Criteria

On questions where the evaluator makes a subjective, 0-5 points judgment, the following scale will be used to assist the evaluator in determining a score.

0 = Failure, no response, completely inadequate
 1 = Poor, inadequate, fails to meet requirement
 2 = Fair, only partially responsive
 3 = Average, meets minimum requirement
 4 = Above average, exceeds minimum requirement
 5 = Excellent

1. Experience with Managed Care (4 points possible)	Criteria
The Offeror's managed care experience operating group pool of more than 10,000 people 1 page limit	(4 points possible.) Use table to calculate points.
2. Quality Assurance (5 points possible)	
NCQA Accreditation 1 page limit	(5 points possible.) <i>HMO/POS Accreditation</i> 5 points for having an accreditation outcome of excellent. 3 points for having an accreditation outcome of commendable. 2 points for having an accreditation outcome of accredited. 1 point for seeking accreditation. Plan must submit confirmation from NCQA that the plan is pursuing accreditation and the date of application must be prior to the release date of the RFP. 0 points for provisional accreditation or denied accreditation. <i>PPO Accreditation</i> 1 point for having an accreditation outcome of Full or One-year. 0 Points for all other accreditation outcomes.

3. Customer Service/ Consumer Satisfaction
(5 points possible)

5 page limit

CAHPS Consumer Rating of Health Plan	(2 points possible.) Full points or no points. (Commercial plans are compared against the commercial state average. Medicaid and CHIP health plans are compared against the national Medicaid and CHIP averages. If a plan does commercial in addition to Medicaid, the commercial numbers will be used. If a health plan has CHIP scores, we will use those numbers regardless of other products the plan offers.) Commercial: Full points unless significantly less than the state average. Medicaid: Full points unless significantly less than the state average. CHIP: Full points unless significantly less than the national average. (If statistical significance is not measured, the Health Plan must be more than 2.0% below the average in order to not receive full points.)
Call Answer Timeliness – Customer Service	(2 points possible.) "The percentage of calls received by the organization's Member services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds." ----- The NCQA national average is 75%. The NCQA 90th percentile is 85%. 1 point for being above 75% OR 2 points being above 85%
Average Time – ID cards sent	(1 point possible.) Average time it takes the Health Plan to send ID cards from the time the Health Plan is notified of a person's enrollment. (1 point for <10 business days or 14 calendar days)

4. Statewide Networks and Provider Contracting (33 points possible) 20 page limit	
Coverage of the Health Plan's hospital network.	(15 points possible) See attached hospital groups points matrix.
Coverage of the Health Plan's physician network.	(15 points total possible.) ----- <i>Urban Counties (Salt Lake, Weber, Davis, and Utah) -</i> (10 points possible) 10 points - 95-100% of Urban provider list 8 points – 90-94.9% of Urban provider list 6 Points – 85-89.9% of Urban provider list 4 Points – 80-84.9% of Urban provider list 2 Points – 75-79.9% of Urban provider list 0 Points – Below 75% of Urban provider list ----- <i>Rural Counties (all counties other than those listed above as urban)-</i> (5 points possible) 5 points – 95-100% of Rural provider list 4 points – 90-94.9% of Rural provider list 3 Points – 85-89.9% of Rural provider list 2 Points – 80-84.9% of Rural provider list 1 Points – 75-79.9% of Rural provider list 0 Points – Below 75% of Rural provider list
Number of hospitals in selected group with Mental Health inpatient facilities	(1 point possible.) Compare with other bidders. 1 point for having the most hospitals. 0.5 point for having a count within two of the health plan with the most hospitals. Otherwise no points.
Number of Mental Health Professionals by Local Health Department	(1 point possible.) 1 point for having the most Local Health Department areas of all bidders with at least two mental health professionals. Mental health professionals, for the purposes of this measure, only include psychiatrists, psychologists, and licensed clinical social workers. 0.5 point for having 90% of the number that the bidder with the most Local Health Department areas has.

Patient Can Get in to See Doctor	(1 points possible.) Evaluator should rate on a five point scale with five being excellent and 0 being non-responsive or completely inadequate. Score will later be converted into a proportion of the points possible listed above. Do the assurance methods proposed lead to the desired outcome? Does the health plan have an appointment scheduling standard for primary care providers for urgent care and routine care? Does the health plan have other standards or measures in this area? Are the health plan's procedures to measure compliance with its standards sufficient?
5. Management of Medical Expenses Including Mental Health Costs (2 points possible) 10 page limit	
Utilization Management plan (including Mental health costs) AND Other methods of managing medical expenses	(2 points possible) Evaluator should rate on a five point scale with five being excellent and 0 being non-responsive or completely inadequate. Score will later be converted into a proportion of the points possible listed above. How well does the plan monitor over and under utilization? (ER visitation, mental health services, abuse of prescription drugs) How well does the plan identify and correct aberrant physician behavior? (physician monitoring and education) How well will this plan result in identification of important enrollee service problems or potential problems including utilization of service patterns by provider and recipient? How well do the other methods used by the plan assure appropriate utilization and promote high quality, cost effective care? How clearly do the utilization management

	plan and other methods of managing medical expenses help control costs?
6. Pharmacy Benefit Management (2 points possible) 5 page limit	
Overall discount from average wholesale price (AWP) - Generics	(1 point possible). Discount /25 = points
Overall discount from average wholesale price (AWP) – Brand Name	(1 point possible). Discount /20 = points
Expected Rebates (informational only, not used in scoring)	n/a
7. Efficiency of Claim Paying Procedures (4 points possible) 5 page limit	
How third party liabilities (TPL) are identified and collected	(2 points possible) ----- <i>Subrogation process</i> (1 point possible) Evaluator should rate on a five point scale with five being excellent and 0 being non-responsive or completely inadequate. Score will later be converted into a proportion of the points possible listed above. Does the entity have the ability to identify, collect, and maintain TPL cases? Does the offeror ensure that liabilities not collected immediately can be maintained? Does the process include flagging certain accident-related ICD-9 claims codes? Does the health plan gather additional information on the accident from the insured through phone calls or a questionnaire? Does the process include litigation when appropriate to recover funds that should have been paid by another party? ----- <i>Coordination of Benefits</i> (1 points possible) Evaluator should rate on a five point scale with five being excellent and 0 being non-responsive or completely inadequate. Score

	will later be converted into a proportion of the points possible listed above. When the health plan learns there is other insurance, do they request an explanation of benefits from the other payer? Will the coordination of benefits plan help to <u>identify and verify</u> other sources of health insurance for CHIP enrollees?
The percentage of "clean" claims paid within 30 days of receipt AND The percentage of "clean" claims paid within 90 days of receipt	(2 points possible) Full points or no points. Those that meet or exceed both of the following standards get full points. 90% within 30 days. 99% within 90 days. No points awarded if one or both standards are not reached.
8. Cost (45 points possible)	<i>See Attachment M, Cost points scoring methodology</i>
TOTAL EVALUATION POINTS	(100 points possible)

Attachment K

Managed Care Experience Points Table

		Covered Lives (Current)			
		0-10,000	10,001 - 50,000	50,001- 100,000	Over 100,000
Experience (Years)	Less than 1	0	0	0	0
	1-2	0	1	2	2
	3-5	0	2	3	3
	6-9	0	3	3	4
	10+	0	3	4	4

A partial year's experience will be rounded to the nearest whole number except when the total experience is less than one year.

(Example 1: An offeror with 2.4 years experience and 11,000 covered lives would be rounded down to 2 years and given the score of 1)

(Example 2: An offeror with 9.6 years experience and 60,000 covered lives would be rounded up to 10 years and given the score of 4)

Attachment L

Hospital Network Scoring Worksheet

Group 1 - The number of Hospitals in this Group	Points
1	0
2	0
3	0
4	0
5	0
6	0
7	0
8	0
9	1
10	1
11	2
12	2
13	3
14	4
15	5
16	8
17	11
18	14

5 or more hospitals from group 2 (see Attachment G)	+1
---	----

Minimum Group 1 Requirements:

Intermountain Medical Center
 Primary Children's Medical Center
 Utah Valley Regional Medical Center
 McKay-Dee Medical Center
 Dixie Regional Medical Center
 Logan Regional Medical Center

Minimum Group 2 Requirements:

San Juan Hospital
 Gunnison Valley Hospital

Example: A health plan has contracts or letters of intent with 17 of the 18 hospitals in the Group 1 Network and also has contracts or letters of intent with 7 hospitals in Group 2. This health plan would receive 11 points + 1 point = 12 points.

Note: The hospitals listed as minimum Group 1 network requirements are counted in the count of hospitals for the group.

San Juan and Gunnison Valley hospitals are counted as Group 2 hospitals (2 of the 5 necessary to score 1 point)

Attachment M

Cost Points Scoring Methodology

Possible Cost Points = 45

Formula

Cost Points Awarded = Possible Cost Points - (Possible Cost Points * 4 * ((Health Plan Bid - Lowest Network Bid)/Lowest Network Bid))

A Health Plan cannot receive negative points on this measure.

The Lowest bid will be used in the formula except when the lowest bid is below the "bid floor" (unreasonably low) at which time the network's "bid floor" described in a separate, non-public document will be used in its place. When a Health Plan's bid is below the "bid floor", the formula is not used for that Health Plan, and that Health Plan will receive the full cost points possible.

Attachment N

RFP Evaluation Score Sheet

CHIP 2009 Medical RFP
Solicitation #

Offeror Name:
Evaluator:
Date:

Details	Points Possible	Rating Scale	Score or Evaluator Rating	Weight	Points
1. Experience with Managed Care (4 points possible)	---	---	---	---	---
Managed care experience operating large group pool of more than 10,000 people	4	0 to 4	4	1.00	4
Experience (years)					
Cover Lives (current)					
TOTAL SECTION POINTS					4
2. Quality Assurance (5 points possible)	---	---	---	---	---
NCQA Accreditation	5	0 to 5	5	1.00	5
Accreditation Status					
TOTAL SECTION POINTS					5
3. Customer Service/ Consumer Satisfaction (5 points possible)	---	---	---	---	---
CAHPS Consumer Rating of Health Plan	2	0 to 2	2	1.00	2
Measured against which of the following: CHIP national average, Medicaid national average, or state Commercial averages					
CAHPS rating					
Call Answer Timeliness - Customer Service	2	0 to 2	2	1.00	2
Percentage of calls answered within 30 seconds					
Average Time – ID Cards sent	1	0 to 1	1	1.00	1
Average time (specify calendar or business days)					
TOTAL SECTION POINTS					5
4. Statewide Networks, Provider Contracting (33 points possible)	---	---	---	---	---
Coverage of the Health Plan's hospital network.	15	0 to 15	15	1.00	15
Hospitals in Group 1					
Number of hospitals from group 2					
Coverage of the Health Plan's physician network (SL, Weber, Davis, and Utah counties)	10	0 to 10	10	1.00	10
Percent match with urban provider list					
Coverage of the Health Plan's physician network (All other counties)	5	0 to 5	5	1.00	5
Percent match with rural provider list					
Number of Hospitals in network with Mental Health inpatient facilities	1	0 to 1	1	1.00	1
Count of the Offeror with the most hospitals with Mental Health Inpatient facilities					
Hospitals with Mental Health Inpatient facilities					

RFP Evaluation Score Sheet

Details	Points Possible	Rating Scale	Score or Evaluator Rating	Weight	Points
Number of Mental Health Professional by Local Health Department	---	---	---	---	---
Count of the Offeror with the most Local Health Departments in State with at least two mental health professionals	1	0 to 1	1	1.00	1
Number of Local Health Departments with at least two Mental Health Providers, Percentage of the count of the Offeror with the most					
Patient Can Get in to See Doctor	1	Evaluator 0 to 5	5	0.20	1
Notes					
TOTAL SECTION POINTS					33
5. Management of Medical Expenses Including Mental Health Costs (2 points possible)	---	---	---	---	---
Utilization Management plan and other methods of managing medical expenses	2	Evaluator 0 to 5	5	0.40	2
Notes					
TOTAL SECTION POINTS					2
6. Pharmacy Benefit Management (2 points possible)	---	---	---	---	---
Overall discount from average wholesale price (AWP) - Generics	1	0 to 1	1	1.00	1
Discount - Generics (Generic Discount / 25)					
Overall discount from average wholesale price (AWP) - Brand Name	1	0 to 1	1	1.00	1
Discount - Brand Name (Brand Name Discount / 20)					
TOTAL SECTION POINTS					2
7. Efficiency of Claim Paying Procedures (4 points possible)	---	---	---	---	---
How third party liabilities (TPL) are identified and collected - Subrogation	1	Evaluator 0 to 5	5	0.20	1
Notes					
How third party liabilities (TPL) are identified and collected - Coordination of Benefits	1	Evaluator 0 to 5	5	0.20	1
Notes					
The percentage of "clean" claims paid within 30 days of receipt AND The percentage of "clean" claims paid within 90 days of receipt	2	0 or 2	2	1.00	2
Percentage of "clean" claims paid within 30 days of receipt					
Percentage of "clean" claims paid within 90 days of receipt					
TOTAL SECTION POINTS					4
8. Cost (45 points possible)	45	0 to 45	45	1.00	45
TOTAL EVALUATION POINTS	(100 points possible)	n/a			100

Question and Answers for Bid #NO10001 - Childrens Health Insurance Program (CHIP) Medical Services

OVERALL BID QUESTIONS

Question 1

"Item #1 under "Minimum Qualifications" (page 4 of the RFP) identifies the licensure requirements for participation in the CHIP managed care program. This section appears to identify two different standards for establishing whether or not an Offeror meets the minimum qualifications regarding licensure. That Item Provides:

1. Licensure. Participation in CHIP managed care is limited to organizations that are licensed by the Department of Insurance. The Department of Health will not award contracts to any organizations prior to their becoming licensed. Evidence of license should be submitted with the proposal.

The second sentence of item #1 appears to require licensure by the Offeror at the time DOH makes an award of the contract, which the RFP indicates will be September 21, 2009. However, the first sentence appears to require licensure at the time of "participation" which can be interpreted to mean at the time of "go-live" or when the plan begins accepting members, which is after the contract award. Please clarify whether a license must be obtained prior to an award of the contract, or prior to "participation". Also, please confirm that, the requirement that "evidence of license be submitted with the proposal" is satisfied if an Offeror has submitted a licensure application for an HMO Certificate of Authority to the Utah Department of Insurance prior to the proposal due date.

Given this question impacts determinations on whether or not an entity meets the minimum qualifications to submit a bid, please expedite the response to this question. (Submitted: Jul 15, 2009 1:32:47 PM MDT)

Answer

- The Department will accept a licensure application for an HMO Certificate of Authority to the Utah Department of Insurance as initial evidence of licensure. However, the Offeror will need to submit evidence of the receipt of the certificate of authority by September 21. (Answered: Jul 20, 2009 12:54:51 PM MDT)

Question 2

On page 13 of the RFP under the section labeled, "Proposal Response Format", item 3 A. specifies a requirement to provide a narrative of the offeror's assessment of the work and offeror's approach, ability and resources to meet program needs. Please clarify, does the Department require detailed responses to Attachments B through F in the scope of work? (Submitted: Jul 16, 2009 10:21:26 AM MDT)

Question 3

Is CHIP enrollment growing? (Submitted: Jul 20, 2009 11:49:05 AM MDT)

Answer

- Yes. In the last year, enrollment has increased by over 5,000 children. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question 4

Could you provide an overview of your plans? (Submitted: Jul 20, 2009 11:49:52 AM MDT)

Answer

- CHIP has two plans, Public Employees Health Plan (PEHP) and Molina Healthcare of Utah. Both plans are statewide. Enrollment numbers are provided on page 15 of the solicitation packet. More information on CHIP, the plans, and providers can be found at www.health.utah.gov/chip and the links from that website. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question 5

Which plan receives the enrollee if the enrollee doesn't choose a plan? (Submitted: Jul 20, 2009 11:50:52 AM MDT)

Answer

- CHIP used to have a default plan for Enrollees who didn't select a plan. However, CHIPRA has now required an equitable assignment between the plans. For the most part, enrollees who don't select a plan will be assigned alternately between the two plans. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question 6

What is the history of legislation regarding the RFP? (Submitted: Jul 20, 2009 11:51:32 AM MDT)

Answer

- A bill in the 2008 legislative session required CHIP to do an RFP in 2008. CHIP did the RFP for both sides of its business and only received a bid for one side. Molina Healthcare of Utah was awarded the contract for that side of CHIP's business. By law, because no one bid on the Intermountain side of CHIP's business, PEHP continued on as CHIP's health plan for the time. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question 7

What will happen to the enrollees currently on PEHP when the new company takes over? (Submitted: Jul 20, 2009 11:52:01 AM MDT)

Answer

- If we have a January 1 implementation, we will notify existing PEHP clients that they will be transferring to the new plan on Jan 1. We will let them know that if they have a concern about the new plan (e.g. hospitals or physicians), they can switch to Molina at that time.

If we have a July 1 implementation, we will notify PEHP clients that PEHP will end June 30 and that a new plan offering similar networks will begin July 1. We will also let them know that it is plan switch time (May) and that they can elect to move to Molina if they wish. If they take no action, they will be enrolled in the new plan. All CHIP enrollees on both plans will be allowed to switch plans during this period. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question 8

Is there a fee schedule for providers like in Medicaid? (Submitted: Jul 20, 2009 11:52:28 AM MDT)

Answer

- No. The health plans negotiate rates with providers. (Answered: Jul 20, 2009 11:54:54 AM MDT)

Question Deadline: Aug 10, 2009 3:00:00 PM MDT