APPENDIX B – TO
IDAHO MEDICAID
PROVIDER AGREEMENT

IDAHO MEDICAID PLUS PLAN

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I. Special Terms and Conditions

A. DEFINITIONS. As used in the Contract, the following terms shall have the meanings set forth below:

1. Contract shall mean the Contract Cover Sheet, these Special Terms and Conditions, State of Idaho Standard Contract Terms and Conditions, and all Attachments identified on the Contract Cover Sheet. The Contract shall also include any negotiated and executed amendment to the Contract or any task order negotiated, executed, and implemented pursuant to provisions of the Contract.

2. Contract Manager shall mean that person appointed by the IDHW to administer the Contract on behalf of the IDHW. "Contract Manager" includes, except as otherwise provided in the Contract, an authorized representative of the Contract Manager acting within the scope of his or her authority. The IDHW may change the designated Contract Manager from time to time by providing notice to Health Plan as provided in the Contract.

3. IDHW shall mean the State of Idaho, Department of Health and Welfare, its divisions, sections, offices, units, or other subdivisions, and its officers, employees, and agents.

4. Health Plan shall mean the health insurer administering the Idaho Medicaid Plus Plan).

B. CONTRACT EFFECTIVENESS. It is understood that this Contract or any Amendment is effective when it is signed by both parties, or at a later date if specified in the Contract or Amendment. The Health Plan shall not render services to the IDHW until the Contract or Amendment has become effective. The IDHW will not pay for any services rendered prior to the effective date of the Contract or Amendment. It is understood and agreed that this Appendix B shall have no force or effect until such time as the Health Plan has executed the then-in-effect version of Appendix A.

C. REASSIGNMENT OF HEALTH PLAN EMPLOYEES. The IDHW shall have the right, after having consulted with the Health Plan, to require the Health Plan to reassign or otherwise remove from the contract any Health Plan employee or subcontractor found in good faith to be unacceptable to the IDHW.

D. RECORDS AND DATA.

1. Fiscal Records. The Health Plan shall maintain fiscal records, including its books, audit papers, documents, and any other evidence of accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of the Contract.

2. Records Maintenance. The Health Plan shall maintain all records and documents relevant to the Contract for three (3) years from the date of final payment to Health Plan. If an audit, litigation or other action involving records is initiated before the

three (3) year period has expired, the Health Plan shall maintain records until all issues arising out of such actions are resolved, or until an additional three (3) year period has passed, whichever is later. In addition, pursuant to 42 CFR §438.3(u), the Health Plan must retain, as applicable, the following information: enrollee grievance and appeal records as described in §438.416, base data as described in §438.5(c), MLR reports as described in §438.8(k), and the data, information, and documentation specified in §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

3. Termination of Contract. If the existence of the Health Plan is terminated by bankruptcy or any other cause, all program and fiscal records related to the Contract in Health Plan's possession shall become the property of the IDHW and Health Plan shall immediately deliver such records to the Contract Manager.

4. Records Review. All records and documents relevant to the Contract, including but not limited to fiscal records, shall be available for and subject to inspection, review or audit, and copying by the IDHW and other personnel duly authorized by the IDHW, and by federal inspectors or auditors. Health Plan shall make its records available to such parties at all reasonable times, at either the Health Plan's principal place of business or upon premises designated by the IDHW.

5. Accuracy of Data. To the extent any requirement is imposed on Health Plan pursuant to this Contract that is reliant, either in whole or in part, on data provided to Health Plan by the IDHW, the IDHW hereby certifies that said data shall be complete and accurate. In the event such data is not complete and accurate, Health Plan shall be excused from any requirements imposed by this Contract and penalties associated with a failure to meet those requirements.

E. CUSTOMER SERVICE.

1. Telephone. The Health Plan shall have its Enrollee line as a published telephone number that is answered by a live voice eight (8) hours per day including during business hours of 8:00 a.m. - 6:00 p.m. MT, Monday through Friday, with the exception of established State holidays described in Idaho State Code 73.1; http://legislature.idaho.gov/idstat/Title73/T73CH1SECT73-108.htm. Voicemail for Health Plan staff shall provide an option for the caller to obtain immediate assistance if necessary. The Health Plan shall endeavor to return telephone calls the same day, and shall respond to phone calls and e-mails not later than forty-eight (48) hours or two (2) business days after the initial contact, whichever is later.

2. Correspondence. Except for public records requests, the Health Plan shall respond to written correspondence, including e-mail, within two (2) business days. The Health Plan shall provide clear, understandable, timely and accurate written information to IDHW customers as required by this Contract.

3. Policies. The Health Plan shall treat IDHW staff and customers with respect and dignity, and shall demonstrate a caring attitude to all who ask for assistance. The Health

Plan shall have a written customer service policy that describes how customer service will be incorporated into policies and training.

F. BINDING EFFECT OF FEDERAL PURCHASE OR SERVICE REGULATIONS. The Contract is subject to the provisions of any relevant federal regulations and any relevant provisions of agreements between the State of Idaho and the United States, including but not limited to State Plans, in effect at the time the Contract is executed, or which thereafter become effective. Such regulations and agreements are on file in the Central Office of the IDHW and are available for inspection by the Health Plan during regular business hours.

G. FEDERAL AND STATE AUDIT EXCEPTIONS. If a federal or state audit indicates that payments to the Health Plan fail to comply with applicable federal or state laws, rules or regulations, the Health Plan shall refund and pay to the IDHW any compensation paid to Health Plan arising from such noncompliance, plus costs, including audit costs.

H. COMPLIANCE WITH CERTAIN LAWS.

1. HIPAA. The Health Plan acknowledges that it may have an obligation, independent of this contract, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Health Plan shall comply with all amendments to the law and federal regulations made during the term of the Contract.

2. Lobbying

a) The Health Plan certifies that none of the compensation under the Contract has been paid or will be paid by or on behalf of the Health Plan to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the Idaho Legislature in connection with the awarding, continuation, renewal, amendment, or modification of any contract, grant, loan, or cooperative agreement

b) If any funds, other than funds provided by the Contract, have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any governmental agency, a member, officer or employee of Congress or the State Legislature in connection with the Contract, the Health Plan shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions, and submit a copy of such form to the IDHW.

c) The Health Plan shall require that the language of this certification be included in any subcontract, at all tiers, (including grants, subgrants, loans, and cooperative agreements) entered into as a result of the Contract, and that all sub-recipients shall certify and disclose as provided herein.

d) The Health Plan acknowledges that a false certification may be cause for rejection or termination of the Contract, subject Health Plan to a civil penalty, under 31 U.S.C. § 1352, of not less than $10,000.00 and not more than $100,000.00 for each such false statement, and that Health Plan's execution of the Contract is a material representation of fact upon which the IDHW relied in entering the Contract.

3. Qualification. The Health Plan certifies to the best of its knowledge and belief that it and its principals:

a) Are not presently debarred, suspended, under sanction, proposed for debarment, declared ineligible, or voluntarily excluded from performing the terms of the Contract by a government entity (federal, state or local);

b) Are not excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

c) Have not, within a three (3) year period preceding the Contract, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

d) Are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in paragraph 2 of this certification; and

e) Have not within a three (3) year period preceding the Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

f) The Health Plan acknowledges that a false statement of this certification may be cause for rejection or termination of the Contract and subject Health Plan, under 18 U.S.C. § 1001, to a fine of up to $10,000.00 or imprisonment for up to 5 years, or both.

4. Faith-Based Organization. If the Health Plan is a faith-based organization, the Health Plan and all approved subcontractors shall:

a) Segregate contract funds in a separate account.

b) Serve all members without regard to religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice.

c) Ensure that IDHW-referred clients' participation in religious activities, including worship, scripture study, prayer or proselytization, is only on a voluntary basis.

d) Notify members of the religious nature of the organization, their right to be served without religious discrimination, their right not to take part in religious activities, their right to request an alternative provider and the process for doing so.

e) Ensure that contract funds are not expended on inherently religious activities.

f) Comply with applicable terms of 42 CFR Parts 54, 54a, and 45 CFR Parts 260 and 1050.

5. Tribes. If the Health Plan is a Tribe, the Health Plan and IDHW recognize that services performed pursuant to this Contract by the Health Plan and all approved subcontractors within reservation boundaries are subject to applicable laws, ordinances and regulations of the Tribe. Nothing in this Contract should be construed as a waiver of sovereign immunity.

I. CONFLICT OF INTEREST.

1. Public Official. No official or employee of the IDHW and no other public official of the State of Idaho or the United States government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract shall, prior to the termination of the Contract, voluntarily acquire any personal interest, direct or indirect, in the Contract or proposed Contract.

2. Health Plan. The Health Plan covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of its services hereunder. The Health Plan further covenants that in the performance of the Contract, no person who has any such known interests shall be employed.

J. REMEDIES.

1. PAYMENT PROCESS. The provisions of this section shall supplement and not replace the State of Idaho Standard Contract Terms and Conditions.

2. MONITORING PROCESS.

a) The purpose of performance monitoring is to:

(1) Determine the degree to which the program is accomplishing its goals and objectives;

(2) Provide measurements of program results and effectiveness;

(3) Evaluate efficiency in the allocation of resources; and

(4) Assess compliance with the contract and applicable statutes and regulations.

b) Failure to meet the thresholds established for Performance Indicators or other contract requirements constitutes breach of the contract and may result in the initiation of remedial action at the discretion of IDHW.

c) IDHW will engage in ongoing contract monitoring, which may include performance monitoring of the Health Plan. This may include review of documentation as well as onsite monitoring at any operational facilities and business offices that handle any component of the Contract requirements. Documentation requested for the purposes of contract monitoring that is part of the Health Plan's routine operations must be supplied to the contract monitor within three (3) business days of the request. Documentation that requires research, data collection, compilation of reports, or additional labor must be supplied to the contract monitor within ten (10) business days of the request or a mutually agreed upon date.

d) During any type of performance monitoring, the Health Plan or any network provider or subcontractor will provide to IDHW any client's treatment records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other requested documents and data as requested when at the discretion of IDHW it is determined to be required to assess the performance of the Health Plan, a network provider or subcontractor.

e) If monitoring activities are conducted at a provider location they will be conducted in a manner so as not to disrupt the provision of treatment to clients.

f) Any monitoring performed may or may not be scheduled in advance, and may last for several days.

g) The performance level of the Health Plan or a network provider or subcontractor may affect the frequency of the monitoring.

h) IDHW reserves the right to monitor any aspect of the contract, not just those elements identified in the Performance Indicators or Contract Requirements.

i) Additionally, if IDHW receives continual unresolved client or provider network complaints regarding service issues, IDHW will initiate a focused monitoring of that area, utilizing at least one of the performance criteria listed in this document. IDHW will then follow the reporting, cure period, and appeal process listed below.

j) Areas in which performance deficiencies have been found may be followed continually, or subsequently re-examined as designated by IDHW.

k) All monitoring is designed and will be performed in accordance with the following standards:

(1) United States Code

(2) Code of Federal Regulations

(3) Idaho Code

(4) Idaho Administrative Code

(5) This Contract

(6) Approved Medicaid waiver programs

(7) National Accreditation Standards

(8) Department of Health and Welfare Policies and Procedures

l) General requirements applicable to all clients will typically be assessed via a randomly selected data review of approximately ten percent (10%) sample of client files at a provider location. Other requirements, relevant to a segment of the client population, may be reviewed using a higher percentage, up to one hundred percent (100%) of the records of a sub-population. Areas in which performance deficiencies have been found may be re-examined in the subsequent quarter or follow up period, as designated by IDHW, in order to gauge progress towards satisfactory performance.

m) Monitoring Report and Appeal. The IDHW Contract Monitor will issue a Monitoring Report to the Health Plan that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the Health Plan. Upon request by the Health Plan, IDHW will meet with the Health Plan within ten (10) business days of their receipt of the Monitoring Report regarding the results. The Health Plan may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The Health Plan must specifically address each disputed finding and justification for the appeal of the finding. The Health Plan is required to provide all documents necessary to dispute monitor results with its written appeal. IDHW will render a final written decision on the appeal to the Health Plan within ten (10) business days of receipt of the Health Plan's dispute information, unless the parties agree in writing to extend the decision period.

n) Breach Cure Period. If the Health Plan does not dispute the findings, the Health Plan shall have ten (10) business days from the date of IDHW's monitoring report to cure the deficiencies found. If the Health Plan appeals the monitoring report, the Health Plan shall have ten (10) business days from the date of IDHW's final written decision to cure the deficiencies. If IDHW is not satisfied that the Health Plan has resolved the deficiencies, or made substantial progress toward resolution, IDHW may assess the amounts listed below as liquidated damages for each day the deficiency remains uncured.

3. Remedial Action. Notwithstanding any conflicting provision in the State of Idaho Standard Contract Terms and Conditions, and in addition to any remedies available to

IDHW under law or equity, IDHW may at its sole discretion require one (1) or more of the following remedial actions, taking into account the nature of the deficiency, if any, of the services or products that do not conform to Contract requirements: (1) require the Health Plan to take prompt corrective action or promptly submit and implement a corrective action plan to ensure that performance conforms to Contract requirements; (2) reduce payment to reflect the reduced value of services received; (3) require the Health Plan to subcontract all or part of a service at no additional cost to IDHW; (4) withhold payment or require payment of actual damages caused by the deficiency; (5) withhold payment or require repayment of an overpayment or duplicate payment; (6) withhold payment or require payment of liquidated damages, as more particularly set forth below; (7) secure products or services and deduct the costs of products or services from payments to the Health Plan; or (8) terminate the Contract pursuant to section 2 of the State of Idaho Standard Contract Terms and Conditions. No remedy conferred by any of the specific provisions of the Contract is intended to be exclusive of any other remedy, and each and every remedy shall be cumulative and shall be in addition to every other remedy given hereunder, now or hereafter existing at law or in equity or by statute or otherwise. The election of any one or more remedies by either party shall not constitute a waiver of the right to pursue other available remedies.

Optional temporary management may be imposed by IDHW if there is continued egregious behavior by the Health plan including criteria described in 42 CFR § 438.700, behavior contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act, substantial risk to enrollee's health, or if temporary management is necessary to ensure the health of Enrollees while improvements are made to remedy violations under 42 CFR § 438.700 or until there is an orderly termination or reorganization of the Health Plan.

IDHW must impose temporary management if it finds the Health Plan has failed to meet the substantive requirements in section 1903(m) or section 1932 of the Act in accordance with 42 CFR § 438.706 (b). IDHW will not delay imposition of temporary management to provide a hearing before imposing this sanction. IDHW will not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur. IDHW will notify Enrollees that temporary management has been imposed and of their right to disenroll.

4. Corrective Actions, Liquidated Damages and Sanctions Related to Information Systems. Within five (5) business days of receipt of notice from IDHW of the occurrence of a problem with the provision and/or intake of encounter data or enrollment file, the Health Plan will provide IDHW with full written documentation that includes acknowledgement of receipt of the notice, a corrective action plan describing how the Health Plan has addressed or will address the immediate problem and how the Health Plan will prevent the problem from recurring.

In the event that the Health Plan fails to correct errors which prevent processing of encounter or enrollment data as required by IDHW, fails to submit a corrective action

plan as requested or required, or fails to comply with an accepted corrective action plan, IDHW may assess remedies.

Continued or repeated failure to submit clean encounter data may result in the application of additional damages or sanctions, or be considered a breach of the Contract.

In the event that the Health Plan is unable to research or address reported errors in encounter data as required by IDHW, the Health Plan will submit to IDHW a corrective action plan describing how the Health Plan will research and address the errors and how the Health Plan will prevent the problem from recurring within five (5) business days of receipt of notice from IDHW that encounter data records submitted by the Health Plan have been rejected.

In the event that the Health Plan fails to address or resolve problems with Enrollee or provider enrollment records in a timely manner as required by IDHW, which will include failure to submit a corrective action plan as requested or required, or failure to comply with an accepted corrective action plan.

Continued or repeated failure to address reported errors may result in additional damages or sanctions including but not limited to being considered a breach of the Contract.

5. Sanctions by CMS. Payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR 438.730. Sanctions may include civil monetary penalties; suspension of all new enrollments, including default enrollment, after the effective date of the sanction; suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or IDHW is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and other additional sanctions allowed under state or federal regulation that address areas of noncompliance.

6. Liquidated Damages. IDHW and Health Plan agree that it will be extremely impractical and difficult to determine the actual damages that IDHW will sustain in the event the Health Plan fails to perform under the Contract. IDHW may, in its discretion, assess liquidated damages as more particularly set forth below.

It is the intent of IDHW to monitor the Health Plan's performance in a continuous and ongoing effort to ensure that all requirements are being met in full. The parties acknowledge that actual and consequential damages to IDHW arising from the failure of the Health Plan to comply with the terms of the contract are uncertain and difficult to ascertain. The parties further acknowledge that delays in the Health Plan's compliance with the terms of the contract will prevent IDHW from satisfying certain federal requirements imposed and that a longer delay or repeated delays by the Health Plan are likely to give rise to an increase in the actual and consequential damages to IDHW, the Health Plan's provider network, and Enrollees whose health and well-being may be

jeopardized. Specifically, IDHW may be subject to federal recoupment and litigation arising from the failure of the Health Plan to satisfy its requirements under the contract and the amount of such damages is not possible to ascertain at the effective date of the contract. Due to the foregoing, IDHW may, in its discretion, assess the liquidated damages as more particularly described below.

The parties agree that the liquidated damages specified in this section are reasonable. IDHW shall notify the Health Plan in writing of the assessment of liquidated damages, which can be cumulative. Withholding of payment by IDHW or payment of liquidated damages by the Health Plan shall not relieve the Health Plan from its obligations under the Contract.

The Health Plan shall not be liable for liquidated damages for a failure that results from an occurrence beyond its control. Failure to maintain staffing levels identified in the contract will not be considered an occurrence beyond the Health Plan control with the exception of failure due to acts of God or the public enemy, fires, floods, epidemics, quarantine, restrictions, strikes, or unusually severe weather. Matters of the Health Plan finances shall not be an occurrence beyond its control.

The assessment of liquidated damages shall not constitute a waiver or release of any other remedy IDHW may have under this Contract for Health Plan breach of this Contract, including without limitation, IDHW's right to terminate this Contract, and IDHW shall be entitled in its discretion to recover actual damages caused by Health Plan's failure to perform its obligations under this Contract. However, IDHW will reduce such actual damages by the amounts of liquidated damages received for the same events causing the actual damages. Amounts due to IDHW as liquidated damages may be deducted by IDHW from any money payable to Health Plan under this Contract, or IDHW may bill the Health Plan as a separate item therefor and the Health Plan shall promptly make payments on such bills.

7. Performance Indicators.

a) IDHW reserves the right to monitor the performance of any aspect of the Contract and seek remedial action, not just those elements identified in the Performance Indicators below. Each Performance Indicator has been assigned a threshold. The thresholds have been determined by IDHW.

b) The chart of Performance Indicators below outlines requirements that are subject to liquidated damages. Criteria established in each section of the Scope of Work are subject to change based on updated legal or policy mandates. IDHW shall give the Health Plan written notification ten (10) business days prior to any new criteria being added to the chart or any criteria existing in the chart being changed. Such ten (10) day period shall commence upon the date of mailing or electronic transmission of the notice. IDHW shall maintain a current chart of Performance Indicators and shall provide a copy of the current chart to the Health Plan upon written request.

Scope of Work Subsection	Performance Indicator	Threshold	Review Period
Attachment 8 – Wellness Assessment	Reasonable efforts to complete Wellness Assessments within ninety (90) calendar days based on enrollment date and at least once every twelve (12) months thereafter.	95%	Quarterly
Attachment 9 – Individualized Care Plan	The Individualized Care Plan shall be developed no later than 30 calendar days from the completion of the Wellness Assessment.	95%	Quarterly
Attachment 11- Provider Services Helpline, Enrollee Call Center/Helpdesk, and IVR Requirements	Call Standards 1) Percent of calls answered by a trained representative (non-recorded voice) within 30 seconds or less 2) The average wait time for assistance does not exceed one hundred twenty (120) seconds. 3) Call abandonment rate 4) Percent of provider services helpline and call center/help desk staff trained to provide customer service response to inquiries.	1) 80% 2) The quarterly average must be less than or equal to one hundred twenty (120) seconds. 3) <5% on average based on calls abandoned in the month divided by all incoming calls. 4) 100%	Quarterly
Prompt Payment	Claims Payment 1) Percentage of clean claims paid within thirty (30) calendar days of receipts 2) Percentage of clean claims paid within ninety (90) calendar days of receipt	1) 90% 2) 99%	Quarterly
Reports/Records/ Documentation	Provide reports as outlined in the Reports/Records/Documentation Section. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframe in the specified format.	100%	Quarterly
Care Management	Maintain the Service and Provider Choice form for each Enrollee receiving A&D	100%	Quarterly

	Waiver and PCS.		
Care Management	Investigate issues within sixty (60) days of receiving Enrollee feedback data from IDHW.	100%	Quarterly
Network Adequacy	Maintain a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area	100%	Quarterly

8. Objective Performance Criteria.

a) If the Health Plan considers any new criteria or changes to existing criteria to be a material change to the contract as defined below, it must notify IDHW in writing within the ten (10) business day period set forth above. The Health Plan's notice shall include an explanation identifying why it considers the new criteria or changes to be a material change to the contract. For the purpose of Performance Indicator criteria additions and changes, material changes shall be changes that affect the time, scope or cost of the contract. If the Health Plan timely provided notification to IDHW that the new criteria or changes to the Performance Indicator criteria are material, the parties will then negotiate in good faith to add the new criteria or to change existing criteria via written amendment to the contract.

b) If the Health Plan does not provide notification to IDHW that new or revised criteria are material within the (10) business days from receipt of written notification from IDHW, the new criteria or changed criteria will become part of the contract without further action by the parties. The Health Plan must comply with new criteria or changes to existing criteria within thirty (30) business days of them becoming part of the contract, whether by written amendment or by failure of the Health Plan to provide notice of materiality.

c) The table of Performance Indicators above and the Contract Requirements below are summary charts of criteria for the performance of the Health Plan subject to performance monitoring. Details for each Performance Indicator are provided in Contract sections identified in the aforementioned charts. Each criterion has been assigned a "threshold." Monitoring will determine if the Health Plan is operating above or below the established threshold. If the finding is that the Health Plan is operating below the established threshold with respect to a Performance Metric, liquidated damages may be imposed. Liquidated damages will be based on the amount of time, in

terms of hours, rounded up or down to the nearest number of hours, IDHW must invest to monitor the performance of the Health Plan. The number of hours required is then multiplied by the cost to IDHW (in terms of an hourly rate) for the staff involved. If the Health Plan's results continue to fall below the established thresholds, the time spent on monitoring performance increases and the amount of liquidated damages is increased accordingly as illustrated in the table below.

d) If the Health Plan falls below the threshold for the first follow up monitoring, then level one (see example in table below) liquidated damages will be assessed. The second (follow up) monitoring that does not meet established thresholds will result in assessment of level two (2) liquidated damages. Level three (3) liquidated damages will be assessed for failure to meet performance criteria for a third (3rd) time and for subsequent failures. Rates imposed upon the Health Plan will be calculated using the then-current employee and consultant costs established in the records of IDHW.

DAMAGES	QTY	UNIT		RATE EXAMPLE		PER DAY COSTS (MAY BE ASSESSED IN TERMS OF HOURLY COSTS)
Level One	1	Day	X	$345.28	=	$345.28
Level Two	1	Day	X	$690.56	=	$690.56
Level Three	1	Day	X	$1035.84	=	$1035.84

ill document and discuss liquidated damages with the Health Plan prior to the issuance of notice of the imposition of liquidated damages. The Health Plan will be notified in writing and the appropriate deduction will be made in the next monthly payment following the expiration of any applicable appeal deadline or other applicable cure or notice periods and in accordance with the contract requirements and limitations. If the next monthly payment is insufficient to fully recover liquidated damages, IDHW may, in its discretion require full payment by the Health Plan of the then outstanding liquidated damages or may continue recovering liquidated damages from future payments to the Health Plan.

f) Health Plan's submission and IDHW payment of an invoice reduced as set forth above shall not limit the remedies afforded to IDHW under law and pursuant to the Contract.

9. Invoice Reduction. The Department and the Health Plan agree to the weighting plan below, which assigns a defined weight for each contract requirement performed in

the operations phase. The Weighting Plan will assign a rating to the requirements according to the following schedule:

Weight	**Importance/Impact**
1	Less importance/Low impact
2	Moderate importance/medium impact
3	Critical importance/critical impact

IDHW will assign the following designations to the contract requirements performed in the operations phase and identified in the table below as being subject to invoice reductions:

Fixed per day (FPD)

Fixed per incident (FPI)

Fixed per week (FPW)

Fixed per month (FPM)

IDHW will adjust the monthly amount payable to the Health Plan in accordance with the following methodology and reflect such adjustments on a monthly report to the Health Plan:

Weight	Dollar Reduction	Designation	Calculation
1	$100	FPD	1 x $100 x Days during the invoice period
2	$100	FPD	2 x $100 x Days during the invoice period
3	$100	FPD	3 x $100 x Days during the invoice period
1	$100	FPI	1 x $100 x number of incidents for the invoice period
2	$100	FPI	2 x $100 x number of incidents for the invoice period
3	$100	FPI	3 x $100 x number of incidents for the invoice period
1	$300	FPW	1 x $300 x number of weeks or partial weeks for the invoice period
2	$300	FPW	2 x $300 x number of weeks or partial weeks for the invoice period
3	$300	FPW	3 x $300 x number of weeks or partial weeks for the invoice period
1	$300	FPM	1 x $300 x number of months or partial months for the invoice period
2	$300	FPM	2 x $300 x number of months or partial months for the invoice period
3	$300	FPM	3 x $300 x number of months or partial months for the invoice period

The Health Plan's submission and IDHW's payment of an invoice reduced as set forth above shall not limit the remedies afforded to IDHW under law and pursuant to the provisions of this Remedies section. IDHW reserves the right to waive invoice reductions, at its discretion, if the Health Plan shows marked improvement and is actively taking steps to cure the deficiency.

Contract Section	Contract Requirement	Designation	Weight
Scope of Work – General Requirements	Submit a request to IDHW for review and approval prior to implementing a material change in operations.	FPI	3
Scope of Work – General Requirements	Have a full-time Administrator/Project Director who has clear authority over the general administration and day-to-day business activities of this contract.	FPM	2
Scope of Work – General Requirements	Distribute information prepared by IDHW or the federal government to its Enrollees upon request of the IDHW.	FPI	1
Scope of Work – General Requirements	Allow IDHW, CMS, or their representative to enter the Health Plan's premises, or such other places where duties of this contract are being performed, to inspect, monitor, audit, or otherwise evaluate the work being performed.	FPI	3
Scope of Work – General Requirements	Notify Enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	FPI	3
Scope of Work – Contracts with Providers/ Network Provider Subcontracts	Ensure all contracts with Providers, entities, or organizations providing services incorporate by reference the applicable terms and conditions of this contract, specifies the activities and reporting responsibilities delegated to the Provider, entity, or organization and provides for revoking delegation or imposing other sanctions if the Provider's, entity's, or organization's performance is inadequate.	FPI	2
Scope of Work – Contracts with Providers/ Network Provider Subcontracts	Submit the Network Provider Subcontract template and any subsequent changes to IDHW for review and approval prior to implementation.	FPI	3
Scope of Work – Claims Management	The Health Plan's claims processing system shall run a minimum of one (1) Provider payment cycle per	FPW	3

Contract Section	Contract Requirement	Designation	Weight
System	week, on the same day each week, as determined by the Health Plan and approved in writing by IDHW.		
Attachment 11 - Provider Services Helpline, Enrollee Call Center/Helpdesk, and IVR Requirements	The Health Plan shall ensure that the Call Center/Help Desk information line is staffed a minimum of eight (8) hours per day including during business hours of 8:00 a.m. – 6:00 p.m. Mountain Time, Monday through Friday, with the exception of established State holidays as described in Idaho State Code 73-108.	FPD	3
Attachment 11 – Provider Services Helpline, Enrollee Call Center/Helpdesk, and IVR Requirements	Ensure the toll-free Provider Services Helpline is staffed a minimum of eight (8) hours per day including during business hours of 8:00 a.m. - 6:00 p.m. MT, Monday through Friday, with the exception of established State holidays described in Idaho State Code 73.1; http://legislature.idaho.gov/idstat/Title73/T73CH1SECT73-108.htm.	FPD	1
Scope of Work - Contracts with Providers/ Network Provider Subcontracts	Only contract with Providers that meet the minimum Medicaid Provider qualifications prior to their inclusion on the Provider Enrollment File and/or before payment of their claim.	FPI	3
Scope of Work – Continuity of Care	For a period of up to ninety (90) calendar days, or until the Health Plan completes an Individualized Care Plan, whichever is longer, the Health Plan shall: Allow Enrollees to maintain their current Providers; Honor prior authorizations; and Reimburse Providers at a rate no less than the current Medicaid provider rate.	FPI	3
Scope of Work - Disenrollment	Be responsible for continuing the provision of Covered Services in the event that a disenrollment is not effective within the IDHW system as a result of a	FPI	2

Contract Section	Contract Requirement	Designation	Weight
	Health Plan error, until the Enrollee's disenrollment is successfully processed by IDHW.		

Contract Section	Contract Requirement	Designation	Weight
Scope of Work – Care Management	Provide care coordination services, which include: (1) Monitor the provision of Covered Services, including outcomes, (2) Ensure appropriate referrals and timely two-way transmission of Enrollee information, (3) Support safe transitions for Enrollees moving between care settings. (4) Coordinate services with the services the Enrollee receives from any other Health Plan and share with the other Health Plan the identification and assessment of any Enrollee with special health care needs to avoid duplication of services, (5) Coordinate services with the services the Enrollee receives in FFS Medicaid, (6) Coordinate services with the services the Enrollee receives from community and social support providers, and (7) Coordinate transitions for Enrollees that transition from or to another Health Plan. This includes timely sharing of information necessary to ensure a smooth transition of services for the Enrollee.	FPI	2
Scope of Work – Cost Sharing	Ensure that if cost sharing is required for Medicaid services, it is only to the extent that cost sharing or patient liability responsibilities are required for those services by IDHW in accordance with applicable federal and State statutes and regulations, including but not limited to IDAPA 16.03.05, 16.03.10, and 16.03.18.	FPI	3
Scope of Work – Marketing and Outreach	Obtain prior approval of all marketing and Enrollee communications materials in categories of materials that IDHW requires to be prospectively reviewed.	FPI	3

Contract Section	Contract Requirement	Designation	Weight
Scope of Work – Marketing and Outreach	The Health Plan shall not offer gifts or material, financial, or other incentives to induce potential Enrollees to enroll with the Health Plan or to refer a friend, neighbor, or other person to enroll with the Health Plan.	FPI	3
Scope of Work – Marketing and Outreach	The Health Plan shall not directly or indirectly conduct door-to-door, telephone, or other unsolicited, cold-call contacts or marketing activities.	FPI	3
Scope of Work – Marketing and Outreach	Notify IDHW of significant changes that may affect Provider procedures at least thirty (30) calendar days prior to notifying its Provider network of the changes.	FPI	2
Scope of Work – Marketing and Outreach	Give Providers at least thirty (30) calendar days' advance notice of significant changes that may affect the Providers' procedures (e.g. changes in subcontractors, claims submission procedures, or prior authorization policies).	FPI	2
Scope of Work – Marketing and Outreach	Limit marketing and outreach activities to potential Enrollees to the timeframes specified by IDHW. 1. During implementation, marketing and outreach activities are limited to the sixty (60) days prior to submission of the initial enrollment file. 2. Annually thereafter, marketing and outreach activities are limited to the thirty (30) days prior to and during the open enrollment period.	FPI	2
Scope of Work – Marketing and Outreach	Submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, to the IDHW Contract Monitor.	FPI	2
Scope of Work – Marketing and Outreach	Develop and distribute Provider education and outreach materials pre-approved by IDHW. Electronic distribution is acceptable, except that	FPM	1

Contract Section	Contract Requirement	Designation	Weight
	providers must have the option to request hard copies free of charge. All materials shall be submitted to IDHW for review at least thirty (30) calendar days prior to expected use and distribution. All substantive changes to previously approved education and outreach materials shall be submitted to IDHW for review and approval at least thirty (30) calendar days prior to use.		
Scope of Work – Marketing and Outreach	Develop, print, and distribute IDHW accepted information packets to its network of Providers upon Provider enrollment.	FPI	1
Scope of Work – Marketing and Outreach	Prior to implementation the Health Plan shall offer training to all providers specifically addressing how to submit a clean claim. Copies of the approved Provider Policy & Procedures Manual must be available to providers at that time.	FPW	1
Scope of Work – Grievances and Appeals; and Critical Incident Resolution and Tracking System	Provide the information specified in the Grievances and Appeals and Critical Incident Resolution and Tracking System Sections to all Providers and subcontractors.	FPI	3
Scope of Work – Grievances and Appeals	Information on how to file a Grievance or Appeal shall be provided to the Enrollee at enrollment and annually thereafter.	FPI	3
Scope of Work – Grievances and Appeals	Log all appeals and grievances in an IDHW-approved database such that the IDHW may have access to real-time data regarding grievances and appeals filed with the Health Plan.	FPI	3
Scope of Work – Critical Incident Resolution and Tracking System	Respond to Critical Incidents within twenty-four (24) hours based on the following criteria: Reports of abuse, neglect, or exploitation must be reported immediately to Adult/Child Protection and	FPI	3

Contract Section	Contract Requirement	Designation	Weight
	to the appropriate law enforcement agency within four (4) hours; -A report of any other Critical Incident that may impact the health and/or safety of an Enrollee must be responded to as appropriate to ensure the health and safety of the Enrollee; and -May result in an interim resolution/response until a permanent resolution/response can be accomplished.		
Scope of Work – Grievances and Appeals	The Health Plan shall dispose of Grievances for which there is an immediate health or safety concern as expeditiously as the Enrollee's health condition requires. The Health Plan shall dispose of Grievances for which there is neither an immediate health or safety issue nor a resolution response/time frame defined in rule or law within thirty (30) days. The Health Plan shall dispose of Grievances for which resolution/response time frame are defined in rule or law, within the time frames specified in rule or law.	FPI	2
Scope of Work – Grievances and Appeals	Resolve each Appeal, and provide notice as expeditiously as the Enrollee's health condition requires, not exceeding the following timeframes: *Standard Health Plan level Appeals*. Thirty (30) calendar days from the date the Health Plan receives the Appeal. *Expedited Health Plan level Appeals.* A maximum of three (3) business days after the Health Plan receives the Appeal.	FPI	3
Scope of Work – Utilization Management	For A&D Waiver services and PCS, the Health Plan shall ensure authorization of at least the level of service required by the UAI.	FPI	3

Contract Section	Contract Requirement	Designation	Weight
Program			
Scope of Work – Fraud and Abuse	Implement and maintain surveillance and utilization control programs and procedures in accordance with 42 CFR § 456.3, § 456.4, and § 456.23 to safeguard against unnecessary or inappropriate use of services and improper payments.	FPW	3
Scope of Work – Encounter Data	Submit timely encounter data submissions: Weekly submissions of claims finalized for the week. This includes original claim submissions paid or denied, reversed claims, adjusted claims and voided claims. Pended claims are not required. Weekly submissions of financial data paid on behalf of Idaho Medicaid participants. Weekly submissions of provider related data, including existing data, new additions and changes as specified in the encounter on-boarding manual.	FPI	1
Scope of Work – Encounter Data	Submit a minimum of one (1) batch of encounter data to IDHW's designated agent for all paid and denied claims before 5:00 p.m. MT on Friday of each week via SFTP.	FPI	2
Scope of Work - Encounter Data	Before implementation and at least annually, the Health Plan shall submit an Encounter Data Work Plan that addresses the Health Plan's strategy for monitoring and improving encounter data submission.	FPM	1
Scope of Work – Information Systems	Implement and maintain a Systems Refresh Plan that must be IDHW approved prior to implementation and annually thereafter.	FPI	2
Scope of Work – Information Systems	Ensure the Systems Help Desk (SHD) is available via local and toll-free telephone service and e-mail during the period of time between 6:00 a.m. to 6:00 p.m. Mountain Time, Monday through Friday.	FPD	1

Contract Section	Contract Requirement	Designation	Weight
	Availability times are not required for State holidays.		
Scope of Work – Information Systems	Ensure the Enrollee website is operational twenty-four (24) hours a day, seven (7) days a week, with the exception of scheduled maintenance, which is permitted only between the hours of 12:00 a.m. and 6:00 a.m. Mountain Standard Time. Other time periods may be allowable upon notification of and approval by IDHW.	FPD	1
Scope of Work – Information Systems	Ensure the provider website is operational twenty-four (24) hours a day, seven (7) days a week with the exception of scheduled maintenance, which is permitted only between the hours of 12:00 a.m. and 6:00 a.m. MT.	FPD	1
Scope of Work – Developmental Disability Requirements	DD service plan monitoring shall include at least one (1) face-to-face contact between the DD Targeted Service Coordinator and the Enrollee every ninety (90) calendar days to ensure the services on the DD service plan are provided in coordination with the Enrollee's Individualized Care Plan and the services in the plan are adequate.	FPI	1
Scope of Work – Developmental Disability Requirements	The DD Plan Developer/Plan Monitor/Targeted Service Coordinator shall provide a new service plan to BDDS at least forty five (45) calendar days prior to the expiration date of the current DD service plan.	FPI	1
Scope of Work – Personnel Requirements	Notify the IDHW, in writing, when changes in management and supervisory level staff occur. The Health Plan shall provide the IDHW with resumes of management and supervisory level staff for review and within ten (10) business days of any change.	FPM	2
Scope of Work – Project Task Plan and Service Implementation	Develop and maintain written policies and procedures for each area of the contract for which IDHW requests the development of policies and procedures, at any time during the contract.	FPM	2

Contract Section	Contract Requirement	Designation	Weight
Scope of Work – Cultural Competency	Submit a Cultural Competency Plan within thirty (30) calendar days of the contract effective date that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Native Americans' and Hispanics' needs.	FPM	2
Scope of Work – Cultural Competency	Develop and submit a Nondiscrimination Compliance Plan within thirty (30) calendar days of the contract effective date.	FPM	2
Scope of Work - Health Insurance Portability and Accountability Act (HIPAA) Compliance	Provide training to staff and employees regarding HIPAA-related policies, procedures, Enrollee rights, and penalties prior to the HIPAA implementation deadlines and at least annually thereafter.	FPM	2
Scope of Work - Enrollee Records and Health Information Exchange	Ensure that Enrollee medical records, and any other health and enrollment information that contains individually identifiable health information is used and disclosed in accordance with the privacy requirements set forth in the HIPAA Privacy Rule (45 CFR § 160 and 164, A, E) in accordance with 42 CFR § 438.224	FPI	3
Scope of Work – Subcontracts	Provide the findings of all subcontractor performance monitoring and reviews upon request and notify the IDHW any time a subcontractor is placed on corrective action.	FPI	3
Scope of Work – Covered Services	Maintain service limits that are not more rigorous than they would be under Medicare or Medicaid outside of this contract.	FPW	3
Scope of Work – Covered Services	Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary; provided that the limitation for the service has not been reached.	FPI	3

Contract Section	Contract Requirement	Designation	Weight
Scope of Work – Second Opinion	Provide for a second opinion in any situation where there is a question concerning a diagnosis, the options for surgery, or other treatment of a health condition when requested by an Enrollee or their legal representative.	FPI	2
Scope of Work - Emergency and Post Stabilization Care	Cover emergency services without requiring prior authorization and not limit reimbursement to in-network Providers in accordance with 42 CFR § 438.114.	FPI	3
Scope of Work - Authorization Decisions	Make standard authorization decisions as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension will only be allowed if: The Enrollee or the Provider requests an extension, or The Health Plan justifies to IDHW, upon request, that: (1) The extension is in the Enrollee's interest; and (2) There is a need for additional information where: (i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and (ii) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.	FPI	2
Scope of Work - Authorization Decisions	For expedited service authorization decisions, where the Provider indicates or the Health Plan determines that following the standard authorization timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Health Plan shall make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later	FPI	3

Contract Section	Contract Requirement	Designation	Weight
	than three (3) business days after receipt of the request for service, with a possible extension not to exceed fourteen (14) calendar days. Such extension will only be allowed if: The Enrollee or the Provider requests an extension; or The Health Plan justifies to IDHW upon request, that: (1) The extension is in the Enrollee's interest; and (2) There is a need for additional information where: (i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and (ii) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.		
Scope of Work – Care Management	Ensure that each Enrollee has an assigned Care Specialist.	FPI	3
Scope of Work - Transitional Care Requirements	Develop and implement transitional care protocols and procedures to ensure the Health Plan is notified of the admission of an Enrollee to an inpatient facility and that each Enrollee receives appropriate and cost-effective Medically Necessary services upon discharge.	FPM	2
Scope of Work – Incentive Programs	Obtain IDHW approval prior to implementing any Enrollee incentive programs and before making any changes to an approved incentive.	FPI	2
Scope of Work – Transition Plan	Submit the Transition Plan within ninety (90) calendar days of the contract effective date and an updated Transition Plan to IDHW within one hundred eighty (180) calendar days prior to the conclusion of the contract.	FPW	2
Attachment 10 – Information Systems	Have an electronic document management solution that includes abilities to scan, index, store, and retrieve documents used to transact business with	FPW	2

Contract Section	Contract Requirement	Designation	Weight
	the IDHW.		
Attachment 10 – Information Systems	Load daily Enrollee eligibility and enrollment data within two (2) hours of availability Monday through Friday, 8:00 am to 5:00 pm, or by 8:00 am the following business day if available after normal business hours, for use in eligibility verification, claims processing, and other functions that rely on Enrollee data	FPD	2
Attachment 10 - Information Systems	Ensure all Systems support and maintain compliance with current and future versions of HIPAA Transaction and Code Set requirements, privacy, security, and identifier regulations by their designated compliance dates for electronic health information data exchange and Privacy and Security Rule standards; meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations.	FPI	2
Attachment 10 – Information Systems	Ensure the System is available to support processing and other contract functions ninety-nine percent (99%) of the time for twenty-four (24) hours, except for scheduled maintenance.	FPW	1
Attachment 10 - Information Systems	Provide the necessary computer hardware, software, and any other connectivity equipment required to establish and maintain a system with the capability to securely send and receive data necessary to support the Contract.	FPM	3
Attachment 10 – Information Systems	Ensure for each Enrollee or Potential Enrollee for whom the Health Plan submitted an enrollment or disenrollment record with errors to IDHW, the Health Plan must correct and resubmit the record to IDHW no later than twenty-four (24) hours after IDHW returns the record, provided that IDHW returns the record on a Monday, Tuesday, Wednesday, or Thursday. If IDHW returns the record	FPI	2

Contract Section	Contract Requirement	Designation	Weight
	on a Friday, Saturday, or Sunday, the Health Plan must correct and resubmit the record to IDHW no later than 11:59 pm on the following Monday.		
Attachment 10 – Information Systems	Maintain Systems to perform the data receipt, transmission, integration, management, assessment, and analytics tasks for the contracted functions.	FPI	2

10. Termination for Convenience. The IDHW or the Health Plan may cancel the Contract at any time, with or without cause, upon one-hundred eighty (180) calendar days' written notice to the other party specifying the date of termination. IDHW may terminate the Contract and provide Enrollees' Medicaid benefits through other options if the Health Plan has failed to carry out the substantive terms of its contracts or meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act. Prior to terminating the contract, IDHW will

a) Give Enrollees timely notice of the termination and information, consistent with 42 CFR § 438.10, on their options for receiving Medicaid services following the effective date of termination.

11. Effect of Termination. Upon termination by the IDHW, Health Plan shall: (a) promptly discontinue all work, unless the termination notice directs otherwise; (b) promptly return to the IDHW any property provided by the IDHW pursuant to the Contract; and, (c) deliver or otherwise make available to the IDHW all data, reports, estimates, summaries and such other information and materials as may have been accumulated by Health Plan in performing the Contract, whether completed or in process. Upon termination by the IDHW, the IDHW may take over the services and may award another party a contract to complete the services contemplated by the Contract. Upon termination for cause, the IDHW shall be entitled to reimbursement from Health Plan for losses incurred as a result of the Health Plan's breach.

12. Survival of Terms Any termination, cancellation, or expiration of the Contract notwithstanding, provisions which are intended to survive and continue shall survive and continue, including, but not limited to, the provisions of these Special Terms and Conditions, Sections IV (Records and Data), VII (Federal and State Audit Exceptions), VIII (Compliance with Certain Laws), the Idaho Medicaid Provider Agreement, and the State of Idaho General Terms and Conditions, Sections 9 (Contract Relationship) and 12 (Save Harmless).

K. MISCELLANEOUS.

1. Disposition of Property. At the termination of the Contract, Health Plan shall comply with relevant federal and state laws, rules and regulations and with federal OMB Circulars concerning the disposition of property purchased wholly or in part with funds provided under the Contract.

2. Time of Performance. Time is of the essence with respect to the obligations to be performed under the Contract; therefore, the parties shall strictly comply with all times for performance.

3. Headings. The captions and headings contained herein are for convenience and reference and are not intended to define or limit the scope of any provision of the Contract.

4. Clean Air Act and Federal Water Pollution Control Act. The Health Plan shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. § 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. § 1251 et seq.).

5. Renewal. The IDHW reserves the right to extend this contract for additional periods, not to exceed a total of four (4) years, provided the Health Plan has demonstrated satisfactory performance in the previous year. Any extension or amendment of this contract shall be in writing, signed by both parties.

6. Status. The Health Plan's status under the Contract shall be that of an independent contractor and not that of an agent or employee of IDHW or the State of Idaho. The Health Plan shall be responsible for paying all employment-related taxes and benefits, such as federal and state income tax withholding, social security contributions, worker's compensation and unemployment insurance premiums, health and life insurance premiums, pension contributions and similar items. The Health Plan shall indemnify the IDHW and hold it harmless from any and all claims for taxes, including but not limited to social security taxes, penalties, attorneys' fees and costs that may be made or assessed against the IDHW arising out of the Health Plan's failure to pay such taxes, fees or contributions.

7. Indemnification by the Health Plan. The Health Plan shall indemnify, defend and save harmless the State of Idaho, and the IDHW, its officers, agents, and employees, from and against all liability, claims, damages, losses, expenses, actions, attorney fees and suits whatsoever, including injury or death of others or any employee of the Health Plan or subcontractor caused by or arising out of the Health Plan's negligent or otherwise wrongful performance, act or omission under the Contract or the Health Plan’s failure to comply with any state, federal or local statute, law, regulation, or rule. Nothing in this provision shall extend the Health Plan’s indemnification of the IDHW beyond the liability of the IDHW provided in the Idaho Tort Claim's Act Idaho Code 6-901 et seq., the aggregate of which is limited to $500,000 by Idaho Code 6-926.

8. Public Records. Pursuant to Idaho Code section 74-101 et seq., as amended during the term of the Contract, information or documents received from the Health

Plan may be open to public inspection and copying unless they are exempt from disclosure. The Health Plan shall clearly designate individual documents as "exempt" and shall indicate the basis for such exemption. The Health Plan shall indemnify and defend the Idaho IDHW for honoring such a designation. The Health Plan's failure to designate as exempt any document that is released by the IDHW shall constitute a complete waiver of any and all claims for damages caused by any such release. If the IDHW receives a request for materials claimed exempt by the Health Plan, the Health Plan shall provide the legal defense for such claim.

9. Licenses. For the duration of the Contract, the Health Plan shall maintain in effect, and have in its possession, all licenses required by federal, state and local laws, rules and regulations, including, but not limited to business and professional licenses.

10. Governing Law. The Contract shall be governed by and construed under the laws of the State of Idaho. Any action to enforce the provisions of this Contract shall be brought in State district court in Ada County, Boise, Idaho.

11. Officials Not Personally Liable. In no event shall any official, office, employee or agent of the State of Idaho or of IDHW be liable or responsible for any representation, statement, covenant, warranty or obligation contained in, or made in connection with, the Contract, express or implied.

12. Nonwaiver of Breach. The failure of the IDHW to require strict performance of any term or condition of the Contract, or to exercise any option herein, in any one or all instances shall not be construed to be a waiver or relinquishment of any such term or condition. The same shall be and remain in full force and effect unless there is a prior written waiver by the IDHW.

13. Complete Statement of Terms. The Contract constitutes the entire agreement between the parties hereto and shall supersede all previous proposals, oral or written, negotiations, representations commitments, and all other communications between the parties. The Contract may not be released, discharged, changed, extended, modified, subcontracted or assigned in whole or in part, and no claim for additional services not specifically provided herein will be allowed by the IDHW, except to the extent provided by an instrument in writing signed by a duly authorized representative of the IDHW and the Health Plan.

14. Severability. If any term or provision of the Contract is held by the court to be illegal or unenforceable, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular term or provision held to be invalid.

15. Priority of Contract Documents. The Contract consists of and precedence is established by the order of the following documents incorporated into this Contract: 1) this Appendix B to the Medicaid Provider Agreement; 2) the Attachments identified in Section LVIII. of the Scope of Work; and 3) the Idaho Medicaid Provider Agreement. These documents are complementary and what is required by one shall be binding as if

required by all. In the case of conflict or inconsistency arising under the documents, a higher priority document shall supersede a lower priority document to the extent necessary to resolve any such conflict or inconsistency. No conflict or inconsistency shall be deemed to occur in the event an issue is addressed in one of the above-mentioned documents but is not addressed in another of such documents.

II. General Requirements

A. IDHW Responsibilities: The IDHW will:

1. Provide an IDHW Contract Monitor for ongoing contract administration and contract performance monitoring.

2. Designate an IDHW Contract Monitor who shall have overall responsibility for the management of all aspects of this contract and shall be a member of the implementation team. The IDHW Contract Monitor shall oversee the Health Plan's progress, facilitate issue resolution, coordinate the review of deliverables, and manage the delivery of IDHW resources to the project, consulting with the Health Plan as needed. The IDHW Contract Monitor may designate other IDHW staff to assume designated portions of the IDHW Contract Monitor's responsibility. The IDHW Contract Monitor shall be the central point of communications and any deliverables to the IDHW shall be delivered to the IDHW Contract Monitor and any communication or approval from the IDHW shall be communicated to the Health Plan through the IDHW Contract Monitor. Should disagreements arise between Health Plan staff and the IDHW's Project Team, those disagreements shall be escalated for resolution through each organization's respective reporting structure. Should those disputes remain unresolved after that process, the IDHW's Contract Monitor has the authority to escalate through the Division of Medicaid's leadership to the IDHW's Director who retains ultimate authority to decide the outstanding issue or question.

3. Review any required informational materials prior to release including, but not limited to Enrollee Materials, Provider materials, and Notices.

a) The IDHW Contract Monitor will review draft documents, identify revisions, and return written comments to the Health Plan within agreed upon timeframes.

4. Determine the initial and on-going eligibility of a person for services.

5. Determine the maximum Enrollee cost sharing amount, collect applicable premiums, and will determine the amount of patient liability.

6. In accordance with 42 CFR § 438.60, ensure that no payment is made to a Provider other than the Health Plan for services available under the contract between the IDHW and the Health Plan, except when these payments are provided for in title XIX of the Act, in 42 CFR, or when the IDHW has adjusted the capitation rates paid under the contract, in accordance with 42 CFR § 438.6(c)(5)(v), to make payments for graduate medical education.

7. Provide training and assistance on the IDHW fair hearing system to the Health Plan as needed.

B. Health Plan's Responsibilities: The Health Plan shall:

1. Administer integrated, comprehensive, and seamless health coverage to Medicare and Medicaid Dual Eligible Enrollees (Enrollees). The Health Plan shall offer the Idaho Medicaid Plus plan in the geographic area approved by CMS and the IDHW.
2. Ensure all necessary Medicaid services [including pharmacy, behavioral health, and Long Term Services and Supports (LTSS)] are provided, coordinated, and managed.
3. Ensure services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished consistent with requirements at 42 CFR § 438.210(a)(3)(i) and as amended.
4. Comply with Medicaid Managed Care availability standards established at 42 CFR § 438.206, ensuring the Health Plan and its providers meet State standards for timely access to care and services, taking into account the urgency of need for services.
5. Notify all Enrollees, at the time of enrollment, of the Enrollee's rights to change providers.
6. Not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Enrollee. 42 CFR § 438.210(a)(3)(ii).
7. Comply with provisions of 42 CFR § 438.210 on coverage and authorization of services.
8. Provide assurances satisfactory to IDHW State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the Health Plan's debts if the Health Plan becomes insolvent.
9. Notify Enrollees of their rights and protections, including their rights to change providers and disenroll from the Health Plan, at least annually, in a manner appropriate to their condition and ability to understand.
10. Ensure the requirements in Attachment 1 - Enrollee Rights, are incorporated into business operations.
11. Defend, indemnify and hold harmless Enrollees, the IDHW or its agents, employees, or contractors against any and all claims, costs, damages, or expenses (including attorney's fees) of any type or nature arising from the failure, inability, or refusal of the Health Plan to pay a Provider for Covered Services or supplies.
12. Designate a full-time Administrator/Program Director who has clear authority over the general administration and day-to-day business activities of this contract.
13. Comply with all provisions of State and federal laws, rules, regulations, policies, and guidelines as indicated, amended, or modified that govern performance of

the contractual obligations. This includes, but is not limited to Idaho statutes and administrative rules which can be accessed at http://www.idaho.gov/laws_rules/.

14. Ensure, consistent with 42 CFR § 438.6(h), 42 CFR § 422.208 and 422.210, that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.
15. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient for the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. 42 CFR § 438.102(a)(1)(i)
16. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for any information the Enrollee needs in order to decide among all relevant treatment options. 42 CFR § 438.102(a)(1)(ii)
17. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the risks, benefits, and consequences of treatment or non-treatment. 42 CFR § 438.102(a)(1)(iii)
18. Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 CFR § 438.102(a)(1)(iv).
19. Not be required to provide, reimburse, or provide coverage for a service if the Health Plan objects to the service on moral or religious grounds. 42 CFR § 438.102(a)(2)
20. If the Health Plan elects not to provide, reimburse for, or provide coverage of a service because of an objection on moral or religious grounds, the Health Plan shall furnish information about the services it does not cover:
    a) To IDHW whenever it adopts the policy during the term of the contract and with its application for a Medicaid contract or renewal.
    b) To the Potential Enrollee, consistent with the information requirement provisions of 42 CFR § 438.10, before and during enrollment; and
    c) To Enrollees within ninety (90) calendar days after adopting the policy with respect to any particular service, or a minimum of thirty (30) calendar days before the effective date of the policy. 42 CFR § 438.102(b)
21. Distribute information prepared by IDHW or the federal government to its Enrollees upon request of the IDHW.

22. Maintain and monitor a network of appropriate Providers supported by written subcontractor agreements and sufficient to provide adequate access to Covered Services to meet the needs of the population served. 42 CFR § 422.112
    a) These Providers include behavioral health clinicians with a master's degree, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other Providers.
23. Not employ or contract with, or otherwise pay for any items or services furnished, directed, or prescribed by a Provider that:
    a) Has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act;
    b) Could be excluded under section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;
    c) Has a substantial contractual relationship as defined in 42 CFR § 431.55(h)(3) of this chapter, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act; or
    d) Has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR § 1001.1801 and § 1001.1901.
24. Submit a request to IDHW for review and approval prior to implementing a material change to operations. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, the proposed effective date, and sample Enrollee and Provider notification materials. All material changes to operations shall be communicated to Enrollees or Providers at least thirty (30) calendar days prior to the effective date of the change.
25. Maintain oversight, and be responsible for any functions and responsibilities it delegates to any subcontractor.
26. Report to the IDHW's Contract Monitor any facts regarding irregular activities or practices that may conflict with federal or State rules and regulations discovered during the performance of activities under the contract. Such information may also need to be reported to the Medicaid Fraud Control Unit (MFCU) and the Medicaid Program Integrity Unit, as appropriate.
27. Comply with all requirements for meetings and collaborative workgroups established by IDHW, including, but not limited to preparation, attendance, participation, and documentation. IDHW reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule as necessary. IDHW may require the participation of subcontracted entities when determined necessary.

28. Cooperate fully with any evaluation of the contracted services conducted by IDHW.
29. Allow the IDHW, MFCU, the Office of the Comptroller of the Treasury, the Office of the Inspector General (OIG), the Department of Health and Human Services (DHHS), the Department of Justice (DOJ), to enter the Health Plan's premises, or such other places where duties of this contract are being performed, to inspect, monitor, audit, or otherwise evaluate the work being performed. The Health Plan and all subcontractors or Providers shall supply immediate access to all facilities and assistance the auditing agency's representatives. All inspections and evaluations will be performed in such a manner as to minimize disruption of normal business, except under special circumstances when after-hours admission shall be allowed. Special circumstances shall be determined by the IDHW, MFCU, OIG, DHHS and/or DOJ.
30. Ensure the Health Plan, its Providers, subcontractors, and other entities receiving monies originating by or through IDHW maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, administrative civil and/or criminal investigations, and/or prosecution.
    a) Medical records shall be maintained in their original form unless they are converted to electronic format and remain readable and/or legible; and
    b) Records other than medical records may be kept in an original paper state, preserved on micro media, or may be converted to an electronic format.
31. Retain records that fully disclose the extent of services provided to Enrollees under the contract for a period of five (5) years in accordance with Idaho Code § 56-209(h)(3) and IDAPA § 16.03.09.330 or the time period specified by federal or State law or regulation, whichever is longer.
32. Ensure that IDHW, MFCU, the Office of the Comptroller of the Treasury, the Office of the Inspector General (OIG), the Department of Health and Human Services (DHHS), the Department of Justice (DOJ), and any other duly authorized federal or State agency has immediate and complete access to any and all contract-related records, which include administrative, financial and medical records relating to the delivery of items or services for which IDHW monies are expended, including records maintained by contracted or non-contracted service Providers, within five (5) business days of a request unless a later date is agreed upon by all parties. Requested records shall be provided at no expense to the duly authorized federal or State agency.
33. Cooperate with IDHW or any duly authorized federal or State agency during the course of any claims processing, financial or operational examinations, or any

administrative, civil or criminal investigation, hearing, or prosecution. This cooperation includes, but is not limited to the following:

a) Providing full cooperation and direct and unrestricted access to facilities, information, and staff; including facilities, information, and staff of any management company or claims processing subcontractor; and

b) Maintaining full cooperation and authority for claims processing systems access and mailroom visits, and cooperating fully with detail claims testing for claims processing system compliance.

4. Cooperate fully with audits IDHW may conduct of medical management, including internal audits and audits related to clinical processes and outcomes, Provider networks, and any other aspect of the contract IDHW deems appropriate. IDHW may select any qualified person or organization to conduct the audits.

5. Ensure that procedural safeguards are followed in confidentiality requirements according to IDAPA 16.05.01, Use and Disclosure of Department Records.

III. Personnel Requirements

A. The Health Plan shall:

1. Notify IDHW of any person or corporation that has 5% or more ownership or controlling interest in the entity and submit financial statements for all owners with over 5% ownership.

2. Maintain sufficient staffing capable of fulfilling the requirements of this contract.

3. Notify the IDHW, in writing, when changes in management and supervisory level staff occur. The Health Plan shall provide the IDHW with resumes of management and supervisory level staff for review and within ten (10) business days of any change.

4. Maintain sufficient full-time clinical and support staff to conduct daily business in an orderly manner including but not limited to functions and services in the following areas:

a) Administration,

b) Accounting and finance,

c) Fraud and abuse,

d) UM including prior authorizations,

e) Care coordination,

f) Quality Management/Quality Improvement (QM/QI),

g) Enrollee education and outreach,

h) Appeal system resolution,

i) Enrollee services,

j) Provider services,

k) Provider relations, and

l) Claims processing and reporting.

5. Appoint specific staff to an internal audit function(s).

6. Designate a LTSS Specialist who specializes in issues related to LTSS Providers.

a) The Health Plan shall make the LTSS Provider network aware of this person(s) as the single point of contact for any question or issue LTSS Providers may have.

7. Designate a Behavioral Health Clinical Director.

8. Conduct training of staff in all departments to ensure appropriate functioning in all areas. This training shall be provided to all new staff and on an ongoing basis for current staff.

IV. Project Task Plan and Service Implementation

A. The Health Plan shall develop and utilize a comprehensive written Project Task Plan and Schedule for implementation of the contracted services.

B. The Health Plan shall submit the Project Task Plan and Schedule using a format and computer program agreed upon by the Contract Monitor, within five (5) business days of the effective date of the contract and update it on a weekly basis thereafter; identifying all tasks and including all work necessary to complete the preparation for implementation. It must also identify who is responsible for each task, start and end dates for each task, and include all critical milestones for implementation, and allow fifteen (15) business days for IDHW review of each deliverable. Tasks include but are not limited to the following:

1. All tasks remaining to prepare for implementation that were not verified as completed and approved during readiness review;

2. Work necessary to communicate effectively with Enrollees, Providers, and stakeholders;

3. Creation of marketing materials;

4. Creation of Enrollee Materials that includes all information about being an Enrollee including:

a) The Enrollee Handbook,

b) An Evidence of Coverage Document,

c) A Summary of Benefits,

d) A combined Provider and pharmacy directory, and

e) A formulary that covers outpatient drugs provided by Medicaid;

5. Enrollee and Provider Website Development;

6. Performing an Operational Readiness Test; and

7. Creation of an Operational Readiness checklist to be used for the go/no go decision on implementation.

8. Deliverables identified in the Scope of Work within the stated timeframes.

C. In addition to those items specifically enumerated above, the Health Plan shall develop plans to ensure the completion of all necessary tasks, explicit or implicit, assigned to the Health Plan. Such plans shall be made available to the IDHW when completed and whenever updated.

D. The Health Plan shall describe:

1. All assumptions or constraints identified in developing the Project Task Plan and Schedule;
2. Any identified risks to implementation and strategies to overcome those risks; and
3. How the Health Plan will handle potential and actual problems or delays in meeting the timeline for identified tasks.

E. The Health Plan's Administrator/Project Director, or a designee, to be responsible for successful completion of Health Plan's responsibilities and overseeing and monitoring the Health Plan's staff on a day-to-day basis as they undertake project activities. The Administrator/Project Director, or designee, shall also work closely with the IDHW Contract Monitor and assist in coordinating IDHW resources. The Health Plan's Administrator/Project Director, or designee, shall maintain the Work Plan.

F. The Health Plan's Administrator/Project Director, or designee, and relevant Health Plan staff shall meet with IDHW within ten (10) business days of the contract effective date, and provide a written weekly Project Status Report and the updated Project Task Plan and Schedule to the IDHW Contract Monitor and other IDHW staff one (1) business day prior to the weekly project status meeting thereafter. The purpose of the status meeting is for the Health Plan to communicate actual progress, identify problems, recommend courses of action, and obtain approval for making modifications to the Task Plan. The weekly Project Status Meetings and the weekly written Project Status Report are required from the contract effective date through two (2) months of full statewide implementation, unless otherwise determined by the IDHW Contract Monitor. The Project Status Report shall identify:

1. Work completed since the last meeting;
2. Work scheduled for the upcoming week;
3. Tasks that are behind schedule;
4. Any information needed from IDHW;
5. Items for discussion or decision;
6. Dependent tasks for tasks behind schedule;
7. Items requiring the IDHW Contract Monitor's attention;

8. Anticipated staffing changes;

9. Risk assessment with proposed risk mitigation actions to keep implementation on time; and

10. Any issues that can affect schedules for project completion.

G. The Health Plan shall ensure that any change to the Project Task Plan and Schedule that results in a significant or milestone date change is identified and communicated to IDHW at the weekly Project Status Meeting along with strategies for addressing any resulting challenges to the timeline for implementation.

H. The Health Plan shall:

1. Prepare agendas for all meetings and distribute agendas and relevant materials at least one (1) business day before a scheduled meeting;
2. Be responsible for documenting all meetings, including attendees, topics discussed, action items, and decisions recommended and/or made with follow-up details. Written summaries of all meetings shall be provided to the IDHW Contract Monitor no later than three (3) business days after the date of each meeting;
3. Prepare and submit a comprehensive set of flow diagrams that clearly depict the agreed upon final work operations, including, but not limited to Enrollee flow, Health Plan workflow, expected IDHW workflow, and data flow within twenty-one (21) calendar days of the effective date of the contract. These diagrams shall aid in the understanding of how the Health Plan will perform work and support training. With a goal to maximize clarity, the Health Plan shall use graphical software that matches what the IDHW currently uses as its platform;
4. Utilize proven project management processes, including use of an Issue/Decision Management Log. This ensures issues, requests, and decisions are recognized, agreed upon, assigned to an owner, monitored, documented, and managed through resolution. The Issue/ Decision Management Log will be reviewed at each Project Status Meeting; and
5. Ensure services are available prior to implementation as demonstrated during Readiness Review.

I. The Health Plan shall demonstrate its readiness and ability to provide Covered Services, demonstrate that LTSS training, experience, and expertise are incorporated into operations and management and to resolve any previously identified operational deficiencies. The Health Plan shall undergo and pass a readiness review process that may include, but is not limited to desk and on-site review of documents provided by the Health Plan, a walk-through of the Health Plan's operations, system demonstrations, including systems connectivity testing, and interviews with Health Plan staff. The scope of the review may include any and all requirements of the contract, as determined by IDHW.

1. The Health Plan shall not enroll Potential Enrollees until IDHW has determined that the Health Plan meets the requirements.

2. Based on the results of the review activities, IDHW will issue a letter of findings and, if needed, will request a corrective action plan from the Health Plan.

V. Written Policies and Procedures

A. The Health Plan shall develop and maintain written policies and procedures for each area of the contract for which IDHW requests the development of policies and procedures, at any time during the contract. If the IDHW determines the Health Plan lacks a policy or procedure required to fulfill the terms of this contract, the Health Plan shall adopt a policy or procedure as directed by IDHW.

B. The Health Plan shall:

1. Maintain written guidelines for developing, reviewing, and approving all policies and procedures;

2. Review all policies and procedures at least annually to ensure they reflect current practice and update them as necessary;

3. Sign and date reviewed policies; and

4. Ensure all medical and quality management policies are reviewed and approved by the Health Plan's Medical Director.

C. Should the IDHW determine a Health Plan policy requires revision; the Health Plan shall work with the IDHW to revise the policy within the timeframes specified.

VI. Approval Process

A. IDHW will specify all deliverables, if they require prior approval, deliverable instructions, submission and approval time frames, and will provide the Health Plan with technical assistance, if required.

B. IDHW must approve deliverables before they are implemented by the Health Plan.

1. At any time that approval of IDHW is required, such approval shall not be considered granted unless IDHW issues its approval in writing.

VII. Enrollee / Provider Materials and Notices

A. Enrollee Material Guidelines: The Health Plan shall develop, print, and distribute Enrollee materials including, but not limited to Enrollee Handbooks, Provider and pharmacy directories, Enrollee newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, system generated letters, and any other additional materials and information provided to Enrollees designed to promote health and/or educate Enrollees, according to the following requirements:

1. Word all Enrollee materials at a sixth (6th) grade reading level, unless IDHW requires otherwise.

2. Ensure all written Enrollee materials are clearly legible with a minimum font size of twelve point (12pt) with the exception of Enrollee identification cards, and unless otherwise required in writing by IDHW.

3. Include an assurance of non-discrimination.

4. Include notification that oral interpretation is available for all non-English languages and that written information is available in prevalent languages at no expense to them and how to access those services. Written materials must include taglines in the prevalent non-English languages in the state explaining the availability of written translation to understand the information provided and the toll-free telephone number of the Health Plan's customer service unit.

5. Translate and make available all written Enrollee materials in Spanish and each Limited English Proficiency group that constitutes five percent (5%) or more of Enrollees or one thousand (1,000) or more Enrollees in the Health Plan's statewide service area, whichever is less.

6. Include notification that each Provider of services must make oral interpretation services for all non-English languages and auxiliary aids, including as TTY/TDY and American Sign Language, available free of charge to each Enrollee.

7. Make all Enrollee materials available in Alternative Formats for Enrollees with special needs within forty-five (45) calendar days of a request at no expense to the Enrollee.

a) Alternative Formats may include, but are not limited to: Braille, large print (printed in a font size no smaller than 18 point), and audio; and shall be based on the needs of the individual Enrollee.

8. Provide written notice to Enrollees of any changes in policies or procedures described in Enrollee materials previously sent to Enrollees at least thirty (30) calendar days before the effective date of the change.

9. Submit all Enrollee materials for review and approval prior to distribution.

10. Obtain IDHW written approval, specific to the use requested, before using any of the following:

a) The Seal of the State of Idaho;

b) The IDHW name;

c) Any other State agency name or logo;

d) The word "free" unless the service is at no cost to all Enrollees. If Enrollees have cost sharing or patient liability responsibilities, the service is not free. Any conditions of payments shall be clearly and conspicuously disclosed in close proximity to the "free" good or service offer; or

e) The use of phrases to encourage enrollment such as "keep your doctor" implying that Enrollees can keep all of their Providers. Enrollee materials shall

not infer that Enrollees may continue to go to their current Provider, unless that particular Provider is an in-network Provider.

11. Provide the Enrollee with written notice of any action within the time frames specified for each type of action consistent with 42 CFR § 438.404.

B. Approval Process for All Enrollee Materials: The Health Plan shall:

1. Submit all Enrollee materials to IDHW on paper and electronic file media, in the format prescribed by IDHW. The Enrollee materials shall be accompanied by a plan that describes the Health Plan's intent and procedure for the use of the Enrollee materials. Enrollee materials developed by a recognized entity having no association with the Health Plan, related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.), or general health improvement shall be submitted for approval. An electronic file for these materials is not required unless requested by IDHW. Electronic files submitted in any other format than those approved by IDHW will not be processed.

2. Submit an electronic version (PDF) of the final printed product, unless otherwise specified by IDHW, when Enrollee materials have been approved in writing by IDHW and within thirty (30) calendar days from the print date. If IDHW requests hard copy original prints, photocopies may not be submitted as a final product. Upon request, the Health Plan shall provide additional original prints of the final product to IDHW.

3. Submit a detailed description of any proposed modification to any approved Enrollee material for written approval by IDHW. Proposed modifications shall be submitted in accordance with the formatting requirements for Enrollee materials.

4. IDHW will review and either approve or deny the Enrollee materials within fifteen (15) business days from the date of submission. In the event IDHW does not approve the materials, IDHW may provide written comments and the Health Plan shall revise and resubmit the Enrollee materials for approval prior to distribution.

5. IDHW reserves the right to notify the Health Plan to discontinue or modify Enrollee materials after approval.

C. Distribution of Enrollee Materials: The Health Plan shall:

1. Distribute to Enrollees and Potential Enrollees information in accordance with 42 CFR § 438.10 including, but not limited to the following materials:

a) Any information required by CMS;

b) A single identification card for accessing all Covered Services provided under the contract;

c) An Evidence of Coverage (EOC) document that includes information about all State-covered and Plan-covered supplemental benefits ;

d) An Annual Notice of Change (ANOC) summarizing all major changes to the Health Plan's covered benefits from one contract year to the next, starting in the second contract year, if the contract is extended;

e) A document that summarizes benefits and contains a concise description of the important aspects of enrolling in the Health Plan's Plan, as well as the benefits offered under the Health Plan, including premiums, cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. The Health Plan shall use a contract-specific SB;

f) A combined Provider and pharmacy directory that includes all Providers of Medicaid services and Supplemental Services.

(1) The Provider Directory must include the following information about each of the Health Plan's network providers:

(a) The provider's name as well as any group affiliation;

(b) Street address(es);

(c) Telephone number(s);

(d) Web site URL, as appropriate;

(e) Specialty, as appropriate;

(f) Whether the provider will accept new Enrollees;

(g) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and.

(h) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

(2) The Provider Directory must include the details listed under (1) for the following provider types:

(a) Pharmacies;

(b) Behavioral health providers; and

(c) LTSS providers, as appropriate.

(3) Information included in a paper version of the Provider Directory must be updated at least monthly and an electronic Provider Directory must be updated no later than thirty (30) calendar days after the Health Plan receives updated provider information.

g) A comprehensive integrated formulary that includes outpatient prescription drugs (including both generic and name brand) that are covered under Medicaid, and what tier each medication is on ;

h) Notification of Formulary Changes per the requirement at 42 CFR § 423.120(b)(5) that the Health Plan provide at least sixty (60) days' advance

notice also applies to the Health Plan for outpatient prescription or over-the-counter drugs or products covered under Medicaid;

i) An Enrollee Handbook that includes the requirements in Attachment 2 - Enrollee Handbook.

j) Welcome letter;

k) Enrollee Rights and Responsibilities document;

l) Proof of health insurance coverage document;

m) An Explanation of the following:

(1) The charges for which the Potential Enrollee will be liable;

(2) The Potential Enrollee's authorization for the disclosure and exchange of necessary information between the Health Plan, IDHW, and CMS;

(3) The requirements for use of the Health Plan's network Providers;

(4) The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B, enrolled in Medicaid at the time coverage begins, and he or she used Plan services after the effective date; and

(5) The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the Health Plan has not yet provided the ID card).

n) Other materials as determined by IDHW.

2. Distribute upon request, to any Enrollee who requests it, the following information:

a) Information regarding the structure and operation of the Health Plan;

b) Description of transactions between the Health Plan and a party of interest as defined in § 1318(b) of the Public Health Service Act:

(1) Any sale, exchange, or leasing of any property between the Health Plan and such a party.

(2) Any furnishing for consideration of goods, services (including management services), or facilities between the Health Plan and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(3) Any lending of money or other extension of credit between the Health Plan and such a party.

c) Information regarding physician incentive plans including, but not limited to:

(1) Whether the Health Plan uses a physician incentive plan that affects the use of referral services;

(2) The type of incentive arrangement; and

(3) Whether stop-loss protection is provided.

D. Network Notice Requirements

1. Enrollee Notification: The Health Plan shall provide written notices to Enrollees that include all notice content requirements specified in applicable federal and State statutes and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective in addition to the Enrollee material guidelines as follows:

a) If a Provider who is providing prior-authorized ongoing courses of treatment for Enrollees becomes unavailable to continue to provide services to Enrollees and the Health Plan is aware of such ongoing courses of treatment, provide written notice to each Enrollee as soon as possible but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination will be waived in instances where a Provider becomes physically unable to care for Enrollees due to illness, dies, fails to provide thirty (30) calendar days' advance notice to the Health Plan, moves from the Geographic Service Area and fails to notify the Health Plan, or fails credentialing; but shall be made immediately upon the Health Plan becoming aware of the circumstances.

b) If a non-PCP Provider, including, but not limited to a specialist or hospital, ceases to be an in-network Provider, provide written notice to each Enrollee seen and/or treated by the non-PCP provider within the previous six (6) months. Notice shall be issued no less than thirty (30) days prior to the effective date of the termination of the non-PCP Provider when possible or immediately upon the Health Plan becoming aware of the termination.

c) If a long-term care Provider ceases to be an in-network Provider, the Health Plan shall provide written notice as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice, to each Enrollee who has chosen or is authorized to receive long-term care services from the Provider. Notices regarding termination by a nursing facility shall comply with applicable federal and State statutes and regulations. The requirement to provide notice thirty (30) calendar days prior to the effective date of termination will be waived in instances where a Provider becomes physically unable to care for Enrollees due to illness, dies, fails to provide thirty (30) calendar days' advance notice to the Health Plan, moves from the Geographic Service Area and fails to notify the Health Plan, or fails

credentialing; but shall be made immediately upon the Health Plan becoming aware of the circumstances.

2. IDHW Notification: The Health Plan shall provide written notices to IDHW that include all notice content requirements specified in applicable federal and State statutes and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective and as follows:

a) When a subcontract that relates to the provision of services to Enrollees or claims processing is being terminated between the Health Plan and a subcontractor, give at least thirty (30) calendar days' prior written notice of the termination to IDHW. Said notices shall include, at a minimum: a statement explaining the Health Plan's intent to change to a new subcontractor for the provision of said services; an effective date for termination and/or change; and any other pertinent information that may be needed to access services. In addition to the prior written notice, the Health Plan shall also provide a transition plan to IDHW within fifteen (15) calendar days, which includes, at a minimum: information regarding handling of the Health Plan's prior authorization requests during and after the transition and the Health Plan's method for ensuring continuity of care is maintained for Enrollees.

b) Notify IDHW in writing of the termination of the Health Plan's Network Provider Subcontract with any hospital, whether the termination is initiated by the hospital or by the Health Plan, no less than thirty (30) calendar days prior to the effective date of the termination.

c) Notify IDHW of any Provider termination and submit an Excel spreadsheet that includes the Provider's name, IDHW Provider identification number, NPI number (if applicable), and the number of Enrollees affected within five (5) business days of the Provider's termination. If the termination was initiated by the Provider, the notice to IDHW shall include a copy of the Provider's notification to the Health Plan. The Health Plan shall maintain documentation of all information, including a copy of the actual Enrollee notice(s) on-site. Upon request, the Health Plan shall provide IDHW a copy of the following: one (1) or more of the actual Enrollee notices mailed, an electronic listing in Excel identifying each Enrollee to whom a notice was sent, a transition plan for the Enrollees affected, and documentation from the Health Plan's mail room or outside vendor indicating the quantity and date Enrollee notices were mailed as proof of compliance with the Enrollee notification requirements.

d) Notify IDHW within five (5) business days of the date that the Network Provider Subcontract was terminated in writing, the terminations of all Network Provider Subcontracts that cause the Health Plan to be out of compliance with the Network Adequacy Standards.

e) Notify IDHW of significant changes that may affect Provider procedures at least thirty (30) calendar days prior to notifying its Provider network of the

changes. The Health Plan shall give Providers at least thirty (30) calendar days' advance notice of significant changes that may affect the Providers' procedures (e.g. changes in subcontractors, claims submission procedures, or prior authorization policies). The Health Plan shall post a notice of the changes on its Provider website to inform both in-network and out-of-network Providers, and make payment policies available to out-of-network Providers upon request.

VIII. Cultural Competency

A. The Health Plan shall:

1. Participate in IDHW's efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. 42 CFR § 438.206

2. Comply with standards 4, 5, 6, and 7 of the National Standards on Culturally and Linguistically Appropriate Services (CLAS). The Health Plan shall make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

3. Submit a Cultural Competency Plan within thirty (30) calendar days of the contract effective date that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services with specific focus on Indian and Hispanic needs that includes the following requirements:

a) Maintain sufficient staff with cultural competency to implement and oversee compliance with the Cultural Competency Plan;

b) Identify Enrollees whose cultural norms and practices may affect their access to health care and include its plan to outreach these Enrollees;

c) Recruit and retain qualified, diverse, and culturally competent clinical staff within the Provider network and offer single case agreements to culturally competent staff outside of its network, if required to meet an Enrollee's needs;

d) Work with Indian and Hispanic Providers to promote the development of these culturally specialized networks of Providers;

e) Monitor the language services provided to all Enrollees, upon request, and address gaps or inadequacies found;

f) Respond to Enrollees with limited English proficiency through the use of bilingual/multicultural staff or language assistance services. Bilingual/multi-cultural staff, at a minimum, shall speak English, Spanish, and any other language spoken by at least five percent (5%) of the population eligible for services;

g) Notify Enrollees that oral interpretation is available for any language, and that written information is available in prevalent languages at no expense to them and provide instruction on how to access those services;

h) Ensure every reasonable effort is made to overcome any barrier that Enrollees may have to receiving services, including any language or other communication barrier; and

i) Ensure network Providers have staff available to communicate with the Enrollee in his or her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Enrollee in his or her spoken language free of charge.

IX. Non-discrimination Compliance

A. IDHW will:

1. Investigate and resolve all alleged acts of discrimination committed by the Health Plan, its employees, and subcontractors.

2. Review the Health Plan's initial investigations and determine the appropriate resolutions for the complaints.

B. IDHW may:

1. Investigate and resolve any complaints concerning alleged acts of discrimination committed by Providers, Provider's employees, and subcontractors.

2. Request the Health Plan's non-discrimination compliance staff assist with conducting any investigations.

C. The Health Plan shall:

1. Comply with all federal and state statutes and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act 42 CFR § 438.6(f)(1), the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Church Amendments (42 U.S.C. 300a-7), Section 245 of the Public Health Service Act (42 U.S.C. 238n), and the Weldon Amendment (Consolidated Appropriations Act 2008, Public Law 110-161, Div. G, Sec. 508 (d), 121 Stat. 1844, 2209) regarding non-discrimination.

2. Develop and submit a Non-discrimination Compliance Plan within thirty (30) calendar days of the contract effective date that includes the following requirements, at a minimum:

a) Emphasize non-discrimination in personnel policies and procedures as it relates to hiring, promoting, operational policies, contracting processes, and participation on advisory/planning boards or committees.

b) Ask all staff to provide their race or ethnic origin and sex. Staff response is voluntary. The Health Plan is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts.

c) Make a standard, approved Discrimination Complaint Form available to Enrollees. The Discrimination Complaint Form shall be provided to Enrollees

upon request, included in the Enrollee Handbook, and available in English and Spanish.

d) Ensure Enrollees receive assistance with submitting complaints to IDHW, upon request.

(1) Inform employees, Providers, and subcontractors how to assist Enrollees with obtaining Discrimination Complaint Forms and how to obtain assistance from the Health Plan with submitting the forms to IDHW and the Health Plan.

e) Ensure all discrimination complaints against the Health Plan, its employees, Providers, Provider's employees, and its subcontractors are resolved according to the following processes:

(1) For complaints concerning alleged acts of discrimination committed by the Health Plan and/or its employees related to the provision of and/or access to Covered Services: (1) Send complaints to IDHW within two (2) business days of the complaint; (2) Assist IDHW during the investigation and resolution of complaints and provide requested information to IDHW; (3) Implement the IDHW approved corrective action plan to resolve the discrimination complaint within the timeframes designated by IDHW; and (4) Ensure any documentation or materials related to the investigation are considered confidential and is not subject to disclosure to any third party, unless disclosure is otherwise required by law.

(2) For complaints concerning alleged acts of discrimination committed by Providers, Providers' employees, and/or subcontractors related to the provision of and/or access to Covered Services: (1) Send complaints reported to the Health Plan to IDHW within two (2) business days from the date the Health Plan learns of such complaints; (2) Begin to document and conduct the initial investigations of the complaints within five (5) business days of receipt of such complaints; (3) Report the determination to IDHW when an initial investigation has been completed. At a minimum, the report shall include the identity of the party filing the complaint; the complainant's relationship to the Health Plan; the circumstances of the complaint; the date the complaint was filed; and the Health Plan's suggested resolution; (4) IDHW will review the Health Plan's initial investigations and determine the appropriate resolutions for the complaints; (5) Implement the IDHW approved corrective action plan to resolve the discrimination complaint within the timeframes designated by IDHW; and (6) Ensure any documentation or materials related to the investigation are considered confidential and is not subject to disclosure to any third party, unless disclosure is otherwise required by law.

3. Develop and submit a Non-discrimination Compliance Training Plan within thirty (30) calendar days of the contract effective date that includes, but is not limited to the following requirements:

a) Written policies and procedures that demonstrate non-discrimination in the provision of and/or access to Covered Services to Enrollees, Enrollees with limited English proficiency, and Enrollees requiring communication assistance in Alternative Formats.

b) Provide non-discrimination compliance training to all Health Plan staff within sixty (60) calendar days of the contract effective date and to all new staff within sixty (60) calendar days of hire.

c) Provide non-discrimination compliance training to all Providers and subcontractors providing direct service to Enrollees within ninety (90) calendar days of the contract effective date and to all new Providers within ninety (90) calendar days of hire.

d) Maintain documented proof of non-discrimination compliance training.

4. Provide Reports on non-discrimination compliance activities as described in the Reports section of this contract.

5. Abide by IDHW's approved resolution of any discrimination complaint, which may include a corrective action plan and/or require the Health Plan to provide additional non-discrimination training on relevant discrimination topics.

X. Health Insurance Portability and Accountability Act (HIPAA) Compliance

A. The Health Plan shall:

1. Acknowledge its designation as a covered entity and/or business associate under the HIPAA regulations and agree to comply with all applicable HIPAA regulations.

2. Inform Enrollees of their privacy rights in the manner specified under the regulations.

3. Provide training to staff and employees regarding HIPAA-related policies, procedures, Enrollee rights, and penalties prior to the HIPAA implementation deadlines and at least annually thereafter.

4. Track training of staff and employees and maintain signed acknowledgements of understanding by staff and employees of the Health Plan's HIPAA policies.

5. Implement and maintain a plan for receiving, creating, accessing, storing, and transmitting Protected Health Information (PHI) in a manner that is compliant with HIPAA standards for electronic data exchange privacy and security requirements (45 CFR § 160, 162 and 164) and addresses the following:

a) Ensure that PHI exchanged between the Health Plan and IDHW is used only for the purposes of treatment, payment, or health care operations and health oversight and its related functions. All PHI not transmitted for these

purposes or for purposes allowed under the Federal HIPAA regulations shall be de-identified by the Health Plan to secure and protect the Enrollee's PHI.

b) Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure.

c) Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Health Plan employees and other persons performing work for the Health Plan to have only minimum necessary access to PHI and personally identifiable data.

d) Planning, development, testing, and implementation of new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets.

e) Concurrent use of multiple versions of electronic transaction standards and codes sets.

f) Registration and certification of new and existing trading partners.

g) Creation, maintenance, and distribution of transaction companion guides for trading partners.

h) A staffing plan for Electronic Data Interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.

i) Strategies for maintaining up-to-date knowledge of HIPAA related mandates with defined or expected future compliance deadlines.

j) Compliance with all applicable HIPAA requirements including, but not limited to the following:

(1) Compliance with the Privacy Rule, Security Rule, and Notification Rule (45 CFR § 164.302-534); the creation of and adherence to Privacy and Security Safeguards and Policies;

(2) Timely Reporting of Violations in the Access, Use and Disclosure of PHI;

(3) Timely Reporting of Privacy and/or Security Incidents; and

(4) Acknowledgement that failure to comply may result in actual damages that the IDHW incurs as a result of the breach.

k) Policies and procedures to periodically audit adherence to all HIPAA regulations, and for which the Health Plan acknowledges and promises to perform, including but not limited to the following obligations and actions:

(1) Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of IDHW agrees to use reasonable and appropriate safeguards to protect the PHI; and

(2) Return or destroy all confidential information upon termination of the contract and certify on oath, in writing, that such return or destruction has been completed. The Health Plan shall identify any PHI

that cannot feasibly be returned or destroyed and upon agreement by the IDHW, shall extend the protections of this contract to such confidential information and limit further uses and disclosures of such confidential information to those purposes that make the return or destruction infeasible, for so long as the Health Plan maintains such confidential information.

6. Obtain and submit a third party certification of their HIPAA transaction compliance no less than ninety (90) calendar days before the start date of operations.

7. Track all security incidents as defined by HIPAA, and as required by the HIPAA Report. The Health Plan shall report in summary fashion such security incidents as defined in the Reports section of this contract.

XI. Enrollee Records and Health Information Exchange

A. The Health Plan shall:

1. Develop and maintain written policies and procedures for maintaining the confidentiality of all medical records and other pertinent information including, but not limited to health and enrollment information.

2. Ensure that Enrollee medical records, and any other health and enrollment information that contains individually identifiable health information, both hard copy and computerized, is used and disclosed in accordance with the privacy requirements set forth in the HIPAA Privacy Rule (45 CFR § 160 and 164, A, E) in accordance with 42 CFR § 438.224.

3. Comply with all applicable federal and State statutes and regulations regarding privacy and confidentiality requirements.

4. Maintain medical records in a manner that is current, detailed, and organized, and that permits effective and confidential patient care and quality review, administrative, civil, and/or criminal investigations and/or prosecutions.

5. Require in-network Providers and subcontractors to maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations, and/or prosecutions.

6. Have medical record keeping policies and procedures that are consistent with 42 CFR § 456 and current National Committee on Quality Assurance (NCQA) standards for medical record documentation and distribute these policies to sites where Covered Services are rendered. At a minimum, the policies and procedures shall address:

a) Confidentiality of medical records;

b) Medical record documentation standards; and

c) The medical record keeping system and standards for the availability of medical records. At a minimum the following shall apply:

(1) As applicable, medical records shall be maintained or available at the site where Covered Services are rendered;

(2) Performance goals to assess the quality of medical record keeping; and

(3) Respect the privacy of Enrollees.

d) Complying with all federal and State legal requirements as they pertain to confidentiality and privacy of Enrollee records, including without limitation HIPAA;

e) Sharing information as requested by Enrollees in writing and/or electronically;

f) Ensuring effective linkages of clinical and management information systems among all Providers in the Provider Network (e.g., acute, specialty, Behavioral Health, and LTSS Providers), leveraging national standards-based statewide Health Information Exchange where applicable;

g) Maintaining a communication network that facilitates Care Coordination, including use by the Health Plan of a single electronic medical record to manage communication and information flow regarding referrals, transitions, and services;

h) Maintaining a single, comprehensive, centralized Enrollee Record that documents the Enrollee's medical, behavioral, functional, and social status and that contains the following:

(1) Enrollees' identifying and demographic information (including race, ethnicity, disability type, primary language, and homelessness) and family/caregiver contact information;

(2) Documentation of each Medicaid service provided, including the date of service, the name of both the referring Provider and the servicing Provider (if different), and their contact information;

(3) Documentation of physical access and programmatic access needs of the Enrollees, as well as needs for accessible medical equipment;

(4) Documentation of communication access needs, including live interpreting services, access to telephone devices and advanced technologies that are hearing aid compatible, and video relay service or point-to-point video for Enrollees who are deaf or hard of hearing;

(5) Documentation of multidisciplinary assessments, including diagnoses, prognoses, reassessments, Individualized Care Plans, behavioral health treatment plan, and treatment and progress notes signed and dated by the appropriate Provider;

(6) Laboratory and radiology reports;

(7) Prescribed medications under the Medicaid benefits, including dosages and any known drug contraindications;

(8) Updates on the Enrollee's involvement and participation in community agencies that are not part of the Provider Network, including any services provided;

(9) Documentation of contacts with family members and persons giving informal support, if any;

(10) Physician orders;

(11) Enrollee's individual advance directives and health care proxy recorded and maintained in a prominent place;

(12) Plan for Emergency Medical Conditions and Urgent Care, including identifying information about any emergency contact persons;

(13) Behavioral health crisis plans, if appropriate; and

(14) Allergies and special dietary needs.

XII. Subcontracts

A. The Health Plan shall:

1. Maintain oversight, and be responsible for any functions and responsibilities it delegates to any subcontractor in accordance with 42 CFR § 438.230.

2. Support all subcontracts by a written agreement that meets the requirements of 42 CFR §§ 434.6 and 438.214(c). The written agreement must

a) Incorporate by reference the applicable terms and conditions of this contract, and specify that the subcontractor agrees to perform the delegated activities and reporting responsibilities in accordance with the terms and conditions of this contract;

b) Specify the activities or obligations, and related reporting responsibilities, that are delegated to the subcontractor;

c) Provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

d) Specify that the subcontractor agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions;

e) Specify that the subcontractor must make available, for the purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Enrollees at no cost to the requesting agency; and

f) Indicate that the IDHW, Medicaid Fraud Control Unit (MFCU), CMS, HHS Inspector General, the Comptroller General, or their designees have the right to immediately audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this contract.

(1) The right to audit will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later

(2) If the IDHW, MFCU, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the IDHW, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

3. Develop and maintain policies and procedures to audit and monitor subcontractors' data, data submission, and performance and implement oversight mechanisms to monitor performance and compliance with contract requirements on an ongoing basis with formal reviews at least quarterly

a) The Health Plan must have in place a process to conduct unannounced on-site visits to obtain records from subcontractors when the Health Plan receives allegations of fraud, waste, or abuse that would be difficult to validate via written requests.

4. Provide the findings of all subcontractor performance monitoring and reviews upon request and notify the IDHW any time a subcontractor is placed on corrective action. If deficiencies or areas requiring improvement are identified, the Health Plan and subcontractor shall take corrective action. IDHW will establish and provide any reporting requirements for incorporating subcontractor performance into reports submitted to IDHW.

5. Ensure that all subcontractors with access to PHI sign a business associate agreement that requires compliance with HIPAA.

6. Not make payment to any agency providing home health services unless the agency provides the Health Plan, on a continuing basis, a surety bond in a form specified under the Social Security Act § 1861(o) and in an amount that is not less than $50,000 or such comparable surety bond as indicated in the Social Security Act § 1903(i)(18).

XIII. Contracts with Providers / Network Provider Subcontracts

A. IDHW will:

1. Not require the Health Plan to contract with Providers beyond the number necessary to meet the needs of its Enrollees and the access standards of this contract; and

2. Not preclude the Health Plan from establishing measures which are consistent with its responsibilities to Enrollees that are designed to maintain quality of services and control costs.

3. Not preclude the Health Plan from using different reimbursement amounts for different specialties or for different practitioners of the same specialty.

4. The Health Plan shall:

5. Provide Covered Services via direct Network Provider Subcontracts or by entering into a subcontract(s) with entities or organizations to provide Covered Services to Enrollees.

6. Ensure all contracts with Providers, entities, or organizations providing services incorporate by reference the applicable terms and conditions of this contract, specifies

the activities and reporting responsibilities delegated to the Provider, entity, or organization and provides for revoking delegation or imposing other sanctions if the Provider's, entity's, or organization's performance is inadequate.

7. Organize records, billing, and payment systems such that each Provider has a unique identifier for billing and payment purposes.

8. Implement and maintain written policies and procedures for the selection and retention of Providers that include the following requirements:

   a) Not discriminate against particular Providers that serve high risk populations or specialize in conditions that require costly treatment per 42 CFR § 438.214(c);

   b) Not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The Health Plan's ability to credential Providers as well as maintain a separate network and not include any willing Provider is not considered discrimination per 42 CFR § 438.12;

   c) Give affected Providers written notice if the Health Plan declines to include individual or groups of Providers in its network;

   d) Maintain all Provider contracts in accordance with the provisions specified in 42 CFR § 438.12 and 42 CFR § 438.214 with respect to the selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination.

   e) Not discriminate against Providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "Federal health care provider conscience protection statutes," referenced individually as the Church Amendments, 42 U.S.C. § 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80;

   f) Provide all necessary training and information to Providers to ensure satisfaction of all Health Plan responsibilities as specified in the contract; and

   g) Not execute Network Provider Subcontracts that contain compensation terms that discourage Providers from serving any specific eligibility category or population covered by this contract.

9. Offer training to assist Fee-for-Service Providers in the transition to the managed care program, including developing the proper administrative capabilities in information technology, billing, systems operations, and tracking enrollment and disenrollment to effectively operate within a managed care environment.

10. Establish written agreements with all in-network Providers in accordance with 42 CFR § 438.206 and the requirements in Attachment 3 - Network Provider Subcontracts.

   a) Providers of LTSS must be Medicaid-enrolled Providers in good standing.

b) For all other Provider categories, the Health Plan may contract with non-Medicaid Providers if they meet the minimum Medicaid Provider qualifications.

(1) Providers must meet the minimum Medicaid Provider qualifications prior to their inclusion on the Provider Enrollment File and/or before payment of their claim.

11. Submit the Network Provider Subcontract template and any subsequent changes to IDHW for review and approval prior to implementation.

12. Comply with the requirements set forth in 42 CFR § 434.6, General requirements, for all contracts and subcontracts.

13. Utilize the IDHW provider file, made available via the IDHW's MMIS contractor, to verify Medicaid provider status and reconcile provider type and specialty.

XIV. Credentialing and Other Certification

A. Provider Credentialing: The Health Plan shall:

1. Completely process credentialing applications from all types of Providers (physical health, behavioral health and long-term care Providers) within one hundred twenty (120) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Provider contract. This includes review, approval, and loading approved applicants to its Provider files in its claims processing system or denying the application and ensuring the Provider is not used under the contract.

2. Ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any applicable federal and State statutes and regulations including, but not limited to practices that violate the provisions of 45 CFR § Part 80, 45 CFR § Part 84, and 45 CFR § Part 90. Notify IDHW when a Provider fails credentialing or re-credentialing, no longer meets Provider standards, or if the ability of a Provider to provide services is limited because of a program integrity reason within thirty (30) calendar days of the denial or limitation. The Health Plan shall provide related and relevant information to IDHW as required by IDHW or federal or State statute and regulations.

3. Terminate, suspend, or deny enrollment to a Provider from its network as appropriate. Notify IDHW of immediately if a Provider is terminated or suspended from the Health Plan's Plan, Idaho Medicaid, Medicare, another state's Medicaid program, or is the subject of a State or Federal licensing action or for any other independent Action. Such Providers are not authorized to continue providing services under this contract. The Health Plan shall deny payment to such Providers for any services provided after being terminated or suspended.

4. Implement and maintain written policies and procedures related to Provider credentialing and re-credentialing that include standards of conduct that articulate the Health Plan's understanding of the requirements and direct and guide the Health Plan's

compliance with all applicable federal and State statutes and regulations related to Provider credentialing. The policies and procedures shall be submitted to IDHW for review and approval prior to implementation of this contract, annually thereafter, and if amended. The policies and procedures shall include:

a) A training plan designed to educate staff in the credentialing and re-credentialing requirements;

b) Provisions for monitoring and auditing compliance with credentialing standards;

c) Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected;

d) A description of the types of Providers that are credentialed;

e) Methods of verifying credentialing assertions, including any evidence of prior Provider sanctions;

f) Prohibition against employment or contracting with Providers excluded from participation in federal health care programs; and

g) Methods for certifying that each Provider license is current with the appropriate Idaho licensing bureau using the license and certification requirements for each individual Provider type.

5. Demonstrate that its Providers are credentialed as provided in this contract within thirty (30) calendar days prior to implementation.

B. Clinical Laboratory Improvement Amendments (CLIA) of 1988:

1. The Health Plan shall comply with the provisions of CLIA 1988 and ensure all laboratory testing sites providing services under this contract have a CLIA identification number and a current CLIA certificate of waiver or certificate of registration.

a) Laboratories with CLIA certificates of waiver shall provide only the types of tests permitted under the terms of their waiver.

b) Laboratories with CLIA certificates of registration may perform a full range of laboratory tests.

XV. Covered Services

A. The Health Plan shall:

1. Provide a benefit package that includes the comprehensive set of Covered Services in the amount, duration, and scope available under the Medicaid State Plan and the Medicaid waiver programs that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, which are defined in Attachment 4 - Plan Benefit Package, including the Medicaid portion of covered services paid by the primary payer. Covered Services are subject to change during the contract. IDHW will communicate information regarding potential changes to Covered Services in advance of any changes.

2. Provide for the full range of Covered Services.

3. Offer at least the same level of Medically Necessary services in the amount, duration and scope an Enrollee has access to under the Medicaid State Plan or 1915(c) Aged and Disabled Waiver (A&D Waiver) for all Covered Services, including organ transplants that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid.

4. Allow Enrollees to file Grievances or Appeals regarding their services. If the Health Plan rules against the Enrollee, ensure the Enrollee that they may appeal the Action through the State fair hearing process after exhausting the Health Plan's Appeals process.

5. Cover inpatient hospital care, inpatient behavioral health care, and nursing facility services only under the following circumstances:

a) Inpatient hospital care after the Enrollee exhausts the Medicare benefit limit per eligibility period or the Medicare lifetime reserve of days;

b) Inpatient behavioral health care in a psychiatric or acute care hospital after the Enrollee exhausts the Medicare benefit limit; or

c) Nursing facility services when there is no Medicare benefit.

6. Pay hospice agencies a per diem amount for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services, consistent with IDAPA § 16.03.10.459.08 and applicable hospice rules in IDAPA § 16.03.10.450-460.

7. Provide for abortions only under the following situations:

a) If the pregnancy is the result of an act of rape or incest, or

b) In the case where a woman suffers from a physical disorder, physical injury, or physical illness; including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

c) No other abortions, regardless of funding, shall be provided as a benefit under the contract.

8. Not provide services which violate the Assisted Suicide Funding Restriction Act of 1997.

XVI. Medical Necessity

A. The Health Plan shall:

1. Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in the Covered Services Section, in accordance with the requirements of this contract.

2. Furnish Covered Services in an amount, duration, or scope reasonably expected to achieve the purpose for which the services are furnished. The Health Plan may place appropriate limits on a service on the basis of Medical Necessity criteria for the purpose of utilization control, provided that

a) The services furnished can reasonable achieve their purpose,

b) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports, and

c) Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.

3. Cover, at minimum, all benefits and services Medically Necessary as described in the Plan Benefit Package including, but not limited to those services that:

a) Prevent, diagnose, or treat health impairments;

b) Allow Enrollees to attain, maintain, or regain functional capacity; or

c) Allow Enrollees receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

4. Maintain service limits that are not more rigorous than they would be under Medicare or Medicaid outside of this contract.

5. Make the criteria for Medical Necessity determinations for all Covered Services available to any contracting Provider and current or Potential Enrollee upon request.

6. Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary; provided that the limitation for the service has not been reached.

7. Not employ utilization control guidelines, whether explicit or de facto, unless supported by a determination of Medical Necessity based upon the needs of the Enrollee.

8. Not employ quantitative coverage limits, whether explicit or de facto, that are more restrictive than Medicaid coverage limits.

9. Establish procedures and Medical Necessity Guidelines for the determination of Medical Necessity of Covered Services. The determination of Medical Necessity shall be made on a case by case basis. The procedures and guidelines shall, at a minimum:

a) Be developed with input from practicing physicians and psychiatrists, when appropriate;

b) Be developed in accordance with standards adopted by national accreditation organizations;

c) Be developed in accordance with the definition of Medical Necessity in Attachment 5 - Contract Definitions;

d) Be updated at least annually or as new treatments, applications, and technologies are adopted as generally accepted professional medical practice;

e) Be evidence-based, if practicable;

f) Be applied in a manner that considers the individual health care needs of the Enrollee.

g) Be consistent with Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS, as applicable; and

XVII. Second Opinion

A. The Health Plan shall provide for a second opinion in any situation where there is a question concerning a diagnosis, the options for surgery, or other treatment of a health condition when requested by an Enrollee or their legal representative. The second opinion shall be provided by an in-network licensed, qualified professional, or the Health Plan may arrange for the ability of the enrollee to obtain one outside of the network. The second opinion shall be provided at no cost to the Enrollee. 42 CFR § 438.206

XVIII. Carved-Out Services and Supplemental Services

A. Carved-Out Services: The Health Plan shall coordinate with the IDHW to ensure Enrollees are linked to the appropriate services for carved-out non-emergency medical transportation, dental services, Developmental Disabilities (DD) Waiver including Targeted Service Coordination, ICF/ID services and 1915(i) State Plan Option services as described in Attachment 4 - Plan Benefit Package. Examples of coordination include, but are not limited to transferring calls from the Call Center/Help Desk information line to IDHW and providing information on how to access these services in Enrollee education materials.

B. Supplemental Services: The Health Plan may provide additional benefits not covered in the Medicaid State Plan that enhance the general health and well-being of its Enrollees, including programs that address preventive health, risk factors, or personal responsibility (Supplemental Services). The Health Plan shall:

1. Not build costs for Supplemental Services into the capitation rate.
2. Offer and provide to all Enrollees any and all Supplemental Services specific to Enrollees for which the Health Plan has received IDHW approval. All Supplemental Services must be approved by IDHW.
3. Not pay for non-covered services unless it is an approved Supplemental Service or as otherwise directed by a court of law.
4. Ensure no Enrollee is balance billed for any reason by any Provider for Supplemental or Covered Services.

XIX. Authorization of Services

A. For the processing of requests for initial and continuing authorizations of Covered Services, the Health Plan shall:

1. Have in place and follow written policies and procedures;
2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and
3. Consult with the requesting Provider, when appropriate.

B. The Health Plan shall authorize services in accordance with 42 CFR § 438.210 and as follows:

1. Ensure all behavioral health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8).

2. Comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between behavioral health and substance use disorder and medical/surgical inpatient, outpatient, and pharmacy benefits as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). This provision does not require Health Plan to ensure MHPAEA compliance with respect to benefits provided by or under another health plan.

3. Authorize Personal Care Services (PCS) and/or A&D Waiver services to meet Enrollees' needs for assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), in accordance with the results of the Uniform Assessment Instrument (UAI). The authorization process shall be integrated with the Health Plan's authorization process for covered physical health and behavioral health services.

4. Not require that PCS and/or A&D Waiver services be ordered by a treating physician, but may consult with the treating physician, as appropriate, regarding the Enrollee's physical health, behavioral health, and LTSS needs to facilitate communication and coordination regarding the Enrollee's physical health, behavioral health, and LTSS.

5. Notify the requesting Provider, in writing, and give the Enrollee written notice of any decision by the Health Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR § 438.404 and shall:

   a) Be produced in a manner, format, and language that can be easily understood;

   b) Be made available in Prevalent Languages, upon request; and

   c) Include information, in the most commonly used languages about how to request translation services and Alternative Formats. Alternative Formats include materials which can be understood by persons with limited English proficiency.

6. Make authorization decisions within the following timeframes:

   a) For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension will only be allowed if:

      (1) The Enrollee or the Provider requests an extension, or

      (2) The Health Plan justifies to IDHW that: (1) The extension is in the Enrollee's interest; and (2) There is a need for additional information where: (i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and (ii) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

(3) The Health Plan provides the Enrollee or Provider with written notice of the reason for the decision to extend the timeframe and inform the Enrollee or Provider of the right to file a grievance if he or she disagrees with that decision

b) For expedited service authorization decisions, where the Provider indicates or the Health Plan determines that following the standard authorization timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than three (3) business days after receipt of the request for service, with a possible extension not to exceed fourteen (14) calendar days. Such extension will only be allowed if:

(1) The Enrollee or the Provider requests an extension; or

(2) The Health Plan justifies to IDHW that: (1) The extension is in the Enrollee's interest; and (2) There is a need for additional information where: (i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and (ii) Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

c) On the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

d) For all covered outpatient drug authorization decisions, provided notice consistent with section 1927(d)(5)(A) of the Social Security Act.

7. Process expedited service authorizations in instances in which an Enrollee's health condition requires an expedited decision including, but not limited to requests for home health services for Enrollees being discharged from a hospital or other inpatient setting when such home health services are needed upon discharge.

8. Not deny payment for a prior authorized service based on the lack of Medical Necessity, provided that the Enrollee was eligible on the date of service, prior authorization of the service was granted by the Health Plan, and the service was provided; unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

9. Cover emergency services without requiring prior authorization or PCP referral, as described in Emergency and Post Stabilization Care Section, regardless of whether these services are provided by an in-network or out-of-network Provider.

10. Have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollees' condition and identified needs for Enrollees needing a course of treatment or regular care monitoring.

11. Not require a PCP referral for Enrollees to access behavioral health services.

12. Not require a PCP referral for pregnant Enrollees to access prenatal care.

13. The Health Plan may require Enrollees to seek a referral from a PCP prior to accessing some or all non-emergency specialty physical health services.

C. The Health Plan may require out-of-network Providers to obtain prior authorization to render any non-self-referral or non-emergent services to Enrollees. If the out-of-network Provider has not obtained such prior authorization, the Health Plan may deny payment to that out-of-network Provider. The Health Plan shall reimburse out-of-network Providers for all authorized, routine care provided to Enrollees.

XX. Enrollment

A. IDHW will:

1. Provide an 834-eligibility file of all members assigned to the Health Plan as outlined in Attachment 10.

2. Not pay a Per Eligible Member Per Month (PMPM) payment for any Enrollee who lost Medicaid eligibility the previous month.

3. Open enrollment schedule:

a) During implementation, potential Enrollees will have a ninety (90) day open enrollment period to make an active selection of a Health Plan. At the conclusion of the open enrollment period, potential Enrollees who have not made an active selection will be assigned by the IDHW based on an algorithm that accounts for case mix to ensure equitable distribution amongst participating Health Plans in accordance with the process described in Attachment 10.

b) Annually thereafter, Enrollees will have a sixty (60) day open enrollment period to make a change to their Health Plan.

c) Newly dual eligible potential Enrollees will have a ninety (90) day enrollment period to make an active selection of a Health Plan. At the conclusion of the open enrollment period, newly dual eligible potential Enrollees who have not made an active selection will be assigned by the IDHW based on an algorithm that accounts for case mix to ensure equitable distribution amongst participating Health Plans.

B. The Health Plan shall:

1. Process all assigned enrollments and reenrollments. Enrollment into the MLTSS program is mandatory for all dual eligible beneficiaries residing in the geographic service area, excluding Tribal members and pregnant women, and is authorized under an approved waiver of Section 1915(b)(4) of the Social Security Act.

2. Accept new enrollments and reenrollments on an ongoing basis, including members that are newly eligible in the service area based on an assignment algorithm that accounts for case mix to ensure equitable distribution amongst participating Health Plans.

3. Verify eligibility of all Enrollees at the time of enrollment and reenrollment utilizing the following criteria:

a) Aged twenty-one (21) or older at the time of enrollment,

b) Eligible for full Medicaid benefits under one of the following categories:

(1) Recipients of Supplemental Security Income (SSI),

(2) SSI-related individuals,

(3) Dual Eligible Qualified Medicare Beneficiary (QMB) Plus individuals,

(4) Dual Eligible Specified Low-Income Medicare Beneficiary (SLMB) Plus individuals,

(5) Full Benefit Dual Eligible (FBDE) individuals,

(6) Recipients of mandatory state supplements,

(7) Recipients of hospice care, or

(8) Recipients of long-term care.

c) Entitled to or enrolled in Medicare Part A,

d) Enrolled in Medicare Part B,

e) Eligible to enroll in a Medicare Part D plan, and

f) Does not have End Stage Renal Disease at the time of enrollment unless they are already enrolled in another health plan operated by the Health Plan.

4. Accept Potential Enrollees in the order in which they apply without restriction. 42 CFR § 438.6(d)(1).

5. Not discriminate against Potential Enrollees eligible to enroll on the basis of health status or need for health care services. 42 CFR § 438.6(d)(3) and 42 CFR § 422.110(a).

6. Not discriminate against Potential Enrollees eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. 42 CFR § 438.6(d)(4)

7. Comply with all federal and State statutes and regulations and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. 42 CFR § 438.6(f)(1)

8. Develop Information Technology (IT) Systems needed and/or modifications to existing Systems to meet enrollment or disenrollment responsibilities at the Health Plan expense.

9. Ensure all enrollments or reenrollments are effective the first day of the month following receipt of a completed enrollment request.

10. Only use Enrollment and Disenrollment Forms and enrollment related notices approved by IDHW.

11. Provide evidence of the received enrollment request to the Enrollee.

12. Issue a confirmation of enrollment notice to all Enrollees within seven (7) calendar days of the enrollment completion.

13. Not construe anything in this contract to impose any obligation on IDHW, whether express or implied, to guarantee any level of enrollment for the Health Plan.

14. Demonstrate to the satisfaction of IDHW that it has the capacity to serve the current number of Enrollees, upon request by IDHW.

15. Provide service coverage for Enrollees who lose Medicaid eligibility during the month through the end of the calendar month.

XXI. Disenrollment

A. IDHW will:

1. Process all involuntary disenrollments.

2. Determine when and if Health Plan's request to terminate the enrollment of an Enrollee will be granted

IDHW will process disenrollment requests for or without cause during the enrollees initial ninety (90) days of coverage pursuant to 2CFR 438.56(c)(2)

3. Determine when a request for disenrollment made by an Enrollee outside of the open enrollment period constitutes a "for cause" request. The following are cause for disenrollment.

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

b) The plan does not, because of moral or religious objections, cover the service the Enrollee seeks;

c) The Enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

d) For Enrollees that use MLTSS, the Enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Health Plan, and, as a result, would experience a disruption in their residence or employment; or

e) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the Enrollee's care needs.

4. Assign an Enrollee who has disenrolled for cause from a Health Plan to another participating Health Plan.

5. Develop a process to evaluate disenrollment requests for Enrollees whose continued enrollment seriously impairs the Health Plan's ability to furnish services to this Enrollee or other Enrollees.

B. The Health Plan shall:

1. Process all cancellations of Voluntary enrollment that occur during the open enrollment period.

2. Process all Voluntary disenrollments that occur during the open enrollment period. Enrollees or their representatives must request voluntary disenrollment orally or in writing.

3. Implement and maintain a mechanism for tracking timely information about all disenrollments from the Health Plan's plan, including the effective date of disenrollment, and a method to notify IDHW of all disenrollments within a timeframe agreed upon by IDHW.

4. Ensure disenrollments "for cause" that occur outside of the open enrollment period are effective on the first calendar day of the following month.

5. Be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

6. Be responsible for continuing the provision of Covered Services in the event that a disenrollment is not effective within the IDHW system as a result of a Health Plan error, until the Enrollee's disenrollment is successfully processed by IDHW.

7. Notify IDHW of any Enrollee who is no longer eligible to remain enrolled in the Health Plan's plan. This includes where an Enrollee is deceased, remains out of state, or their residence in the state cannot be confirmed for more than six (6) consecutive months.

8. Not disenroll of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of the Individualized Care Plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Health Plan may submit a written request, accompanied by supporting documentation, to the IDHW to disenroll an Enrollee, for cause, to ensure that the Health Plan does not request disenrollment for reasons other than those permitted under the contract, for the following reason:

   a) The Enrollee's continued enrollment seriously impairs the Health Plan's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

9. Transfer Enrollee record information promptly to the new Provider upon written request signed by the disenrolled Enrollee.

10. Notify IDHW if the Health Plan becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

XXII. Continuity of Care

A. The Health Plan shall:

1. Ensure continuity of care for medical, behavioral, LTSS, and pharmacy services upon enrollment for Enrollees as described in Attachment 6 - Transition Requirements and shall:

a) Allow Enrollees to maintain their current Providers;

b) Honor prior authorizations; and

c) Reimburse Providers at a rate no less than the current Medicaid Provider rate.

2. Ensure that during the transition period change to a new Provider only occurs in the following circumstances:

a) The Enrollee requests a change;

b) The Provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or

c) The Health Plan or IDHW identify Provider performance issues that affect an Enrollee's health or welfare.

3. Ensure an Enrollee has the option to waive a particular transition requirement as long as:

a) Any such waiver is not the result of the Health Plan's efforts to convince the Enrollee to waive a transition requirement, and

b) The waiver of a transition requirement does not endanger the Enrollee's health or welfare.

4. Reimburse an out-of-network Provider of emergent or urgent care at no less than the Medicaid fee-for-service (FFS) rate applicable for that service.

5. Advise Enrollees who receive care from out-of-network Providers during the transition period, via written notice, that they have received care that would not otherwise be covered at an in-network level and will not be covered once the transition period is ended.

XXIII. Network Adequacy

A. IDHW will regularly monitor the Health Plan's network and will impose corrective action in accordance with the terms of the contract when the Health Plan fails to meet the network adequacy standards.

B. IDHW may grant exceptions to the access standards in Attachment 7 - Access Standards to account for patterns of care for Enrollees and/or the availability of Providers, but will not do so in a manner that will dilute access to care for Enrollees.

C. The Health Plan shall:

1. Provide, directly or by subcontracting with other qualified entities, the full continuum of Medicaid Covered Services to Enrollees, in accordance with the contract. Medicaid Covered Services shall be provided in accordance with the requirements in the approved Medicaid State Plan, including any applicable State Plan Amendments,

1915(b) and/or 1915(c) A&D Waiver, and in accordance with the requirements specified in the contract.

2. Ensure Enrollees have access to an adequate network of pharmacy, behavioral health, and LTSS Providers that are appropriate and capable of addressing the needs of the diverse population, including availability of services that are accessible 24 hours a day, 7 days a week when medically necessary.

   a) The use of telehealth technology, including telephonic and 2-way video, is acceptable and if it meets the minimum standards required by IDHW in Fee for Service Medicaid.

3. Ensure accessibility of Covered Services, including geographic access, appointments, and wait times are in accordance with the access standards in Attachment 7 - Access Standards. In addition, the Health Plan must require providers to offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. These minimum requirements do not release the Health Plan from the requirement to provide or arrange for the provision of any Medically Necessary Covered Service required by its Enrollees.

4. Comply with 42 CFR § 438.206-207 and the following:

   a) Maintain and monitor a network of appropriate Providers that is supported by written agreements and is sufficient to provide adequate and timely access to all services covered under the contract;

   b) Offer an appropriate range of preventive behavioral health, and specialty services that is adequate for the anticipated number of Enrollees for the service area;

   c) Maintain a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area; and

   d) Consider the following in establishing and maintaining the network:

      (1) Anticipated Medicaid enrollment,

      (2) The expected utilization of services, taking into consideration the characteristics and health care needs of the populations,

      (3) The numbers of network Providers who are not accepting new Medicaid patients, and

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

      (5) The geographic location of Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid Enrollees, and whether the location provides physical access for Enrollees with disabilities.

5. Allow each Enrollee to choose his or her health professional to the extent possible and appropriate. 42 CFR § 438.6(m)

6. Ensure all behavioral health services are provided by, or under the supervision of, at least a licensed behavioral health clinician with a master's degree.

7. Ensure Emergency Service Programs (ESPs) are available to Enrollees.

8. Comply with federal law regarding access to Federally Qualified Health Centers (FQHCs). If the Health Plan does not have an in-network FQHC that meets the General Access Standards, the Health Plan shall allow its Enrollees to seek care from an out-of-network FQHC, if available.

   a) The Health Plan shall reimburse any FQHC or Rural Health Clinic at the rates provided in Section 1902(bb) of the Social Security Act.

   b) The Department will provide current price lists with reimbursement rates for FQHCs and Rural Health Clinics.

9. Allow female Enrollees direct access (without requiring a referral) to a women's health specialist who is an in-network Provider for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist per 42 CFR § 438.206.

10. Demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services, and not restrict the choice of the Provider from whom the Enrollee may receive family planning services and supplies.

11. If the Health Plan network is unable to provide necessary services, covered under the contract, to a particular Enrollee, adequately and timely cover these services out of network for the Enrollee, for as long as the Health Plan is unable to provide them.

12. Collaborate with out-of-network providers with respect to payment to ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network. 42 CFR § 438.206(b)(4)(5)

13. Utilize IDHW network adequacy standards as described in Attachment 7 - Access Standards for LTSS and all services for which Medicaid is primary.

14. Ensure home health, durable medical equipment requirements, and any other services for which Medicaid and Medicare coverage may overlap are subject to the more rigorous of the applicable Medicare or Medicaid network adequacy standards.

15. Allow Enrollees to utilize out-of-network Providers if the Health Plan's network is insufficient for the anticipated enrollment. The Health Plan shall do so until such time as the IDHW determines the network adequacy standards have been met.

16. Provide a sixty (60) calendar day advance notice whenever possible to IDHW of changes to the network that may affect access, availability, or network composition.

17. Conduct surveys and office visits to monitor Provider compliance with appointment waiting time standards and report findings and corrective actions as described in the Reports Section. IDHW reserves the right to direct the Health Plan to terminate or modify any Network Provider Subcontract when IDHW determines it to be in the best interest of the State.

18. Submit network reports in accordance with the requirements established in the Reports Section which address adequate capacity and services as specified, no less frequently than

a) Upon entering into initial contract; and

b) At any time there has been a significant change in the Health Plan's operations that would affect adequate capacity and services including

(1) Changes in services, benefits, geographic area or payments; or

(2) Enrollment of a new population in the Health Plan.

20. The Health Plan may require Enrollees to see in-network Providers after the network adequacy standards are met and the network is approved by IDHW; with the exception of family planning and emergency services.

XXIV. LTSS Network Development Plan

A. The Health Plan shall implement and maintain a LTSS Network Development Plan to ensure the adequacy and sufficiency of the LTSS Provider network. The LTSS Network Development Plan shall be submitted to IDHW for approval prior to implementation and annually thereafter. The LTSS Network Development Plan shall include the following at a minimum:

1. Summary of the LTSS Provider network, including community-based residential alternatives, by service and county;

2. Summary of nursing facilities in the Provider network, by county;

3. Monitoring activities to ensure that access standards for LTSS are met, including the requirements in Attachment 7 - Access Standards;

4. Ongoing activities to track and trend each time an Enrollee does not receive initial or ongoing LTSS in accordance with the requirements of this contract due to inadequate Provider capacity. Activities shall include:

a) Identification of systemic issues by service and county,

b) Implementation of remediation and QI activities, and

c) Recording the targeted and actual completion dates for those activities;

5. Description of the Health Plan's work to develop and enhance the existing community-based residential alternatives (including adult residential care) for the elderly and/or adults with physical disabilities. The description must specify all activities to increase capacity, related activities (including Provider recruitment activities), and provide a status update on capacity building;

6. Ongoing activities for Home and Community Based Services (HCBS) Provider development and expansion taking into consideration identified Provider capacity, network deficiencies, service delivery issues, and future needs relating to growth in the number of Enrollees and their long-term needs; and.

7. Ongoing activities to ensure HCBS are delivered in settings consistent with 42 CFR § 441.301(c)(4).

XXV. Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) Requirements

A. The Health Plan shall:

1. Ensure there are sufficient I/T/U Providers in the Health Plan's network to ensure timely access to services available under the contract for Indian Enrollees who are eligible to receive services from such Providers.

2. Allow any Indian who is enrolled in the Health Plan's plan and eligible to receive services from a participating I/T/U Provider, to choose to receive Covered Services from that I/T/U Provider, and if that I/T/U Provider participates in the network as a PCP, to choose that I/T/U as his or her PCP, as long as that Provider has capacity to provide the services.

3. Pay I/T/U Providers, whether participating in the network or not, for Covered Services provided to Indian Enrollees who are eligible to receive services from such Providers either:

a) At a rate negotiated between the Health Plan and the I/T/U Provider, or

b) If there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the Provider were not an I/T/U provider.

4. Reimburse an Indian Health Program or an Urban Indian Organization owned FQHC no less than the Health Plan pays any of its in-network FQHC whether or not it is participating in the Health Plan's network, if an Indian Enrollee seeks care from an Indian Health Program or an Urban Indian Organization-owned FQHC

a) When an I/T/U Provider is not enrolled in Medicaid as an FQHC, regardless of whether it participates in the Health Plan's network or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or, in the absence of a published encounter rate, the amount it would receive it the services were provided under the State Plan's FFS payment methodology.

5. Pay I/T/U Providers for Covered Services provided to an Indian without any reduction for Medicaid cost-sharing amounts, as long as all applicable requirements of this contract are met.

6. Permit an out-of-network I/T/U Provider to refer an Indian Enrollee to a network provider.

7. Not apply any form of Medicaid cost-sharing to Indian Enrollees served by I/T/U Providers, as those terms are defined in section 4 of the Indian Health Care Improvement Act 25 U.S.C. § 1603.

8. Make prompt payment to all I/T/U Providers in its network as required for payments to practitioners in individual or group practices in accordance with 42 CFR § 447.45 and § 447.46.

XXVI. Care Delivery Model

A. The Health Plan shall:

1. Ensure Enrollees receive all Covered Services in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.
2. Ensure all Covered Services are provided to Enrollees in a manner that is sensitive to the Enrollee's functional and cognitive needs, language, and culture; allows for involvement of the Enrollee and caregivers; and is in an appropriate setting.
3. Ensure that care is person-centered and can accommodate and support self-direction.
4. Develop practice standards in consultation with in-network health care professionals, consistent with practice standards set forth by leading academic and national clinical organizations, considering the needs of the Enrollees. Practice standards shall be reviewed and updated as appropriate.
5. Disseminate the practice standards to all affected Providers, and upon request, to Enrollees and Potential Enrollees.
6. Include the practice standards in Network Provider Subcontracts.
7. Review Provider practices to ensure compliance with the practice standards.
8. Ensure decisions for utilization management, Enrollee education, coverage of services, and other areas to which the practice standards apply are consistent with the practice standards.
9. Coordinate with Providers and other payers, as appropriate, to coordinate Enrollee care and benefits

XXVII. Care Management

A. The IDHW will perform all nursing facility Level of Care Assessments which are required as part of the Medicaid eligibility process. The IDHW will perform all other nursing facility Level of Care Assessments, and assessments to determine eligibility for Personal Care Service for a fixed fee of $155.00 per assessment for which the IDHW will submit a monthly invoice to the Health Plan.

1. IDHW will perform reassessments within 364 days of the previous assessment.
2. The Health Plan shall submit requests for necessary nursing facility Level of Care Assessments at least forty-five (45) calendar days prior to the assessment due date.
3. The Health Plan shall submit a remittance to the IDHW for each monthly invoice within thirty (30) days.
4. The Health Plan shall be responsible for all other documentation related to Enrollee eligibility for A&D Waiver or PCS services, as a result of the Level of Care assessment. Documentation must be housed in the Enrollee file within the IDHW assessment tool, unless otherwise specified by the IDHW. Documentation includes, but is not limited to:
    a) Service and Provider Choice Form.
    b) Significant Change Form.
    c) Notice of Change Form.

d) Agency Change Form.

e) Fiscal Intermediary Memorandum of Understanding, if applicable.

5. The Health Plan shall be responsible for managing changes to the Level of Care Assessment that are required as a result of deterioration or improvement in the Enrollee's condition. These changes must be managed by a Registered Nurse and completed within the IDHW assessment tool.

6. The Health Plan may request modifications to the IDHW assessment tool if needed for reporting or automation purposes. The Health Plan and IDHW shall negotiate a fee for IDHW to implement any specialized system functionality.

7. The IDHW shall provide the Health Plan with Enrollee feedback data, which is collected during the Level of Care Assessment process, on a routine basis. Data will include measures related to quality of life and community integration activities.

a) The Health Plan must investigate issues within sixty (60) days of receiving the data from IDHW. The Health Plan's investigation and outcome must be reported to the IDHW on a quarterly basis.

B. The Health Plan shall develop and submit a Care Management Plan to IDHW for review and acceptance during readiness review that includes policies and procedures for care management services to manage, coordinate, and provide continuity of care for all Enrollees that includes the following requirements, at a minimum. The Health Plan shall:

1. Ensure each Enrollee has access to a Care Specialist.

2. Define the roles and responsibilities of the Care Specialist to include:

a) Act as a point of contact for an Enrollee to the Health Plan

(1) Be an individual employed or contracted by the Health Plan

(2) Be trained on providing care coordination to people with disabilities, the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, wellness principles, and the ADA/Olmstead requirements, as needed;

3. Coordinate the completion of the Wellness Assessments;

a) With reasonable efforts made to contact all enrollees within ninety (90) days. Reasonable efforts are defined as documentation of at least three (3) attempts to contact the Enrollee, including two phone calls on different days of the week and at different times of the day, and one letter, unless the Enrollee has refused a Wellness Assessment. Refusals must be documented;

b) A minimum of once every twelve (12) months thereafter or as appropriate when there is a change to the Enrollee's health status, needs, if a significant health care event occurs, or if the Enrollee, caregiver, or Provider requests a reassessment; and

4. Collaborate with facilities on discharge planning and care transition to ensure the inclusion of Idaho Home Choice Money Follows the Person Rebalancing Demonstration (IHCMFP), if appropriate, and to ensure the appropriate safeguards and services are in place after leaving the facility;

5. Provide care coordination services, which include:

a) Monitor the provision of Covered Services, including outcomes,

b) Ensure appropriate referrals and timely two-way transmission of Enrollee information,

c) Support safe transitions for Enrollees moving between care settings,

d) Coordinate services with the services the Enrollee receives from any other Health Plan and share with the other Health Plan the identification and assessment of any Enrollee with special health care needs to avoid duplication of services,

e) Coordinate services with the services the Enrollee receives in FFS Medicaid, and

f) Coordinate services with the services the Enrollee receives from community and social support providers

g) Coordinate transitions for Enrollees that transition from or to another Health Plan. This includes timely sharing of information necessary to ensure a smooth transition of services for the Enrollee.

6. Develop and update an Individualized Care Plan for each Enrollee utilizing the completed UAI results when applicable, with the Enrollee and/or the Enrollee's designated representative as outlined in Attachment 9 - Individualized Care Plan

7. Ensure that Care Specialists meet the following qualifications:

a) An individual with a minimum of a two-year degree or a minimum two years' experience in healthcare or a healthcare-related industry.

b) Care Specialists must operate under direct oversight of a registered nurse, licensed practical nurse, physician's assistant, or a licensed social worker.

B. The Health Plan shall:

1. Conduct all Wellness Assessments within ninety (90) days from the date of enrollment;

2. Submit Care Management Monitoring policies and procedures to IDHW for review and acceptance during readiness review that include a mechanism to verify the accuracy of care management data and amend or correct inaccuracies.

XXVIII. Transitional Care Requirements

A. Except as set forth in Section B. below, the Health Plan shall develop and implement transitional care protocols and procedures to ensure the Health Plan is notified of the admission of an Enrollee to an inpatient facility and that each Enrollee receives appropriate and cost-effective Medically Necessary services upon discharge that include:

1. Processes to encourage residential/rehabilitation facilities provide the prompt notification of the Enrollee's admission to and discharge from an inpatient or residential/rehabilitation setting;

2. Providing comprehensive transitional care as available under the scope of Covered Services to prevent Enrollee avoidable readmission after discharge from an

inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, or treatment facility) and ensure appropriate follow up care;

3. A systematic follow-up protocol to ensure access to follow-up care, including home and community-based services, post discharge.

B. In cases in which the Health Plan does not have primary responsibility for the Enrollee's care, the Health Plan will make reasonable efforts in the circumstances to engage in transitional care planning with the Enrollee's primary plan.

XXIX. LTSS Intake Process

A. The Health Plan shall develop and implement policies and procedures for ongoing identification of Enrollees who may be eligible for LTSS and submit them to IDHW within thirty (30) calendar days of the contract effective date for approval. Policies and procedures shall include:

1. Identification of Enrollees who may be eligible for LTSS using the following criteria:

a) Referral from Enrollee's PCP, specialist, Provider, or other referral source;

b) Self-referral by Enrollee or referral by Enrollee's family or representative;

c) Referral from Health Plan's staff including but not limited to UM staff;

d) Notification of hospital admission; and

e) Periodic review (at least quarterly) of:

(1) Claims or encounter data,

(2) Hospital admission or discharge data,

(3) Pharmacy data, and

(4) Data collected through the UM process.

2. Methods for working with the discharge planner to determine whether LTSS may be needed upon discharge, and if so, methods to ensure the discharge planner completes all applicable screening and/or intake processes immediately to facilitate transition to the most integrated and cost effective LTSS care delivery setting appropriate for Enrollees identified through notification of hospital admission.

3. Providing the Enrollee with information about how to request a re-evaluation for LTSS in the future if it is determined that an Enrollee is ineligible for or does not need LTSS.

XXX. Enrollee Self-Direction of A&D Waiver Services

A. The Health Plan shall:

1. Provide information, choice, and supports that include the availability of an individual to educate and assist the Enrollee in self-direction to promote self-direction of A&D Waiver services by Enrollees or their representative.

2. Allow Enrollee self- direction of the following services through Personal Assistance Agencies (PAA) functioning as Fiscal Intermediary (FI) Agencies:

a) Companion Services,

b) Skilled Nursing,

c) Consultation,

d) Attendant Care,

e) Homemaker,

f) Chore Service, and

3. Allow Enrollees to use FI services from providers that meet qualifications specified in the A&D Waiver located at: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/AandDWaiver.pdf.

4. Pay for services rendered by a FI Agency functioning as an employer of record which includes payment for services, required taxes, and administrative activities for Enrollees who direct their own services.

a) FI Agencies must be enrolled as Medicaid providers to receive payment under this contract.

b) For Enrollees that elect to use an FI agency, a Memorandum of Understanding signed by the Enrollee and FI agency must be housed within the Level of Care assessment tool.

XXXI. Idaho Home Choice Money Follows the Person Rebalancing Demonstration (IHCMFP)

A. IDHW will:

1. Make all final determinations regarding IHCMFP enrollment; and

B. The Health Plan shall implement and maintain policies and procedures to provide information, choice, and to enroll eligible Enrollees who consent to participate in the IHCMFP upon transition from a Qualified Institution to a Qualified Residence within the community that include:

1. Dissemination of information, including program requirements and processes, to eligible Enrollees;

2. Processes to update Enrollees' Individualized Care Plans and complete and submit required referral, consent forms, and documentation to the IDHW IHCMFP Coordinator;

3. Processes that ensure sufficient contact between Care Specialists and Enrollees during the Enrollee's participation in IHCMFP;

4. Collaboration with qualified Transition Managers or a transition management agency to provide up to seventy-two (72) hours of Transition Management Services and up to two thousand dollars ($2,000.00) of Transition Services for each Enrollee participating in IHCMFP; and

5. Methods to track each Enrollee's residency during IHCMFP participation.

XXXII. Marketing and Outreach

A. IDHW will share demographic information with the Health Plan to promote effective marketing and enrollment during the open enrollment period.

B. The Health Plan shall:

1. Limit marketing and outreach activities to potential Enrollees to the timeframes specified by IDHW.

a) During implementation, marketing and outreach activities are limited to the sixty (60) days prior to submission of the initial enrollment file.

b) Annually thereafter, marketing and outreach activities are limited to the thirty (30) days prior to and during the open enrollment month.

2. Be subject to rules governing marketing and Enrollee communications as specified under section 1851(h) of the Social Security Act; 42 CFR § 422.111; § 422.2260 et. seq.; § 423.120(b) and (c); § 423.128; and § 423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

3. Receive prior approval of all marketing and Enrollee communications materials in categories of materials that IDHW requires to be prospectively reviewed. Health Plan materials may be designated as eligible for the File & Use process, as described in 42 CFR § 422.2262(b) and § 423.2262(b), and exempt from prospective review and approval by IDHW.

4. Submit all marketing and Enrollee communication materials, whether prospectively reviewed or not, to the IDHW Contract Monitor.

5. Include a Spanish phrase in Enrollee material to inform Spanish-speaking Enrollees how to obtain a copy of the materials in Spanish.

6. Distribute any marketing materials to all Potential Enrollees.

7. Comply with the information requirements of 42 CFR § 438.10 to ensure that before enrolling the Potential Enrollee receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

8. Begin marketing activity no earlier than sixty (60) calendar days prior to implementation.

9. Participate in state education and outreach plans for educating Enrollees, families and caregivers, Providers, Provider associations, contractors, and community organizations about LTSS; including collaborative efforts to provide educational sessions, newsletters, and notices targeted to LTSS stakeholders prior to, during, and after implementation.

10. Maintain effective systems for engaging Enrollees who use LTSS including convening accessible local and regional Enrollee advisory committees to provide feedback on LTSS operations.

a) To encourage participation, the Health Plan shall provide supports such as transportation, interpreters, personal care assistants, and reasonable accommodations, including compensation, as appropriate.

b) The Health Plan shall provide a quarterly report on their engagement of LTSS Enrollees.

11. Establish at least one (1) Enrollee advisory group and a process for that group to provide input to the governing board.

a) The Health Plan shall ensure the advisory group composition reflects the diversity of Enrollees, including Enrollees accessing LTSS, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations.

b) The Health Plan shall develop meaningful Enrollee input processes as part of their ongoing operations.

C. The Health Plan is prohibited from the following outreach activities:

1. Offer gifts or material, financial, or other incentives to induce Potential Enrollees to enroll with the Health Plan or to refer a friend, neighbor, or other person to enroll with the Health Plan.

2. Directly or indirectly conduct door-to-door, telephone, or other unsolicited Cold-call Contacts or marketing activities.

3. Seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4. Seek to influence a Potential Enrollee's enrollment in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance).

5. Utilize materials and/or outreach activities which could mislead, confuse, or defraud Potential Enrollees or Enrollees, are unfair or deceptive practices, or that otherwise violate federal or State consumer protection statues or regulations. This includes materials which mislead or falsely describe Covered Services, membership, availability, qualifications, and skills of in-network Providers, or materials which misrepresent IDHW, the Health Plan, or CMS.

6. Target Potential Enrollees on the basis of health status or future need for health care services or which otherwise may discriminate against Potential Enrollees eligible for health care services.

7. Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques.

8. Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled.

9. Use of employed, captive, or independent agents or brokers.

10. Making assertions or statements (whether written or oral) that the Health Plan is endorsed by CMS, federal or State government, or similar entity.

11. Making assertions or statements (whether oral or written) that the Potential Enrollees must enroll with the Health Plan in order to obtain or not lose benefits.

12. Using the name of the Health Plan's plan in any form of general marketing without IDHW's prior written approval.

D. The Health Plan may utilize the following optional outreach activities:

1. Post written outreach and promotional materials approved by IDHW at Provider locations and other sites throughout the state.
2. Use television, radio, printed media (including free newspapers), and website postings, for the purpose of outreach or promotion in accordance with the requirements set forth in the contract.
3. Distribute approved outreach and promotional materials by mail to Potential Enrollees throughout the State.
4. Provide non-financial promotional items only if they are offered to everyone who attends a health fair or community sponsored event, regardless of whether or not they enroll with the Health Plan, and only if the items are of a retail value of twenty-five dollars ($25.00) or less.
5. Conduct nursing facility visits and home visits for interested Potential Enrollees only if the Health Plan has documented a request to visit by an individual or a person recognized under IDHW requirements to make this request on behalf of the Potential Enrollee.

E. Provider Education & Outreach Materials and Activities: The Health Plan shall develop and distribute Provider education and outreach materials pre-approved by IDHW. Electronic distribution is acceptable, except that providers must have the option to request hard copies free of charge. All materials shall be submitted to IDHW for review at least thirty (30) calendar days prior to expected use and distribution. All substantive changes to previously approved education and outreach materials shall be submitted to IDHW for review and approval at least thirty (30) calendar days prior to use. The Health Plan shall revise, finalize, and return the documents to the IDHW for final review within ten (10) business days after receipt of revisions identified by the IDHW. Costs associated with developing, printing, and distributing Provider education and outreach materials are the responsibility of the Health Plan. The Health Plan shall:

1. Notify IDHW of significant changes that may affect Provider procedures at least thirty (30) calendar days prior to notifying its Provider network of the changes. The Health Plan shall give Providers at least thirty (30) calendar days' advance notice of significant changes that may affect the Providers' procedures (e.g. changes in subcontractors, claims submission procedures, or prior authorization policies). The Health Plan shall post a notice of the changes on its Provider website to inform both in-network and out-of-network Providers, and make payment policies available to out-of-network Providers upon request.
2. Provide training on Provider Policies and Procedures to all in-network Providers when they are initially enrolled in the Provider network, whenever there are changes in policies or procedures, and upon a Provider's request.
3. Develop and include a Health Plan-designated inventory control number on all Provider education and outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate IDHW's review and approval of materials and document the receipt and approval of original and revised

documents. The Health Plan shall also utilize this control number to track the status of approval internally.

4. Include the State program logo(s) in their marketing or other Provider communication materials upon IDHW request.

5. Obtain IDHW written approval, specific to the use requested, before using any of the following:

a) The Seal of the State of Idaho;

b) The IDHW name; or

c) Any other State agency name or logo.

6. Not interpret any approval given for the use of IDHW or other State agency name or logo as blanket approval.

F. Provider Information Packet: The Health Plan shall develop, print, and distribute IDHW accepted information packets to its network of Providers upon Provider enrollment. Provider Information packets shall include, at minimum, the following:

1. Explanation of the contracted services;

2. Health Plan's contact information (address, telephone number, fax, web site);

3. Health Plan's office hours and days;

4. Information on accessing the Policies and Procedures Manual electronically or manually;

5. Information on urgent and emergent care which includes the following:

a) Notice that prior authorization is not required for an Enrollee to obtain urgent and emergent services from an in-network Provider;

b) Providers are required to inform their patients to what extent and how after hours and urgent care is provided, including how to contact an in-network Provider twenty-four (24) hours a day, seven (7) days a week;

c) The locations where Providers and hospitals furnish urgent and emergent services covered under the contract; and

d) The Enrollee's right to use any in-network Provider for urgent care and any Provider (in and out-of-network) for emergent services.

G. Provider Policy & Procedures Manual: The Health Plan shall maintain and distribute a written Provider Policies and Procedures Manual. The Provider Policies and Procedures Manual shall:

1. Be submitted to the IDHW for review and acceptance prior to initial distribution to Providers and at least sixty (60) calendar days prior to implementation.

2. Be available both electronically and in hard copy upon request, to all Providers, without cost, prior to implementation, when new Providers are initially enrolled, when there are any changes in policies or procedures, and upon a Provider's request.

a) Be submitted to the IDHW for review and acceptance within five (5) business days of updates or changes in operation identified for revision or inclusion by the Health Plan or the IDHW.

b) The Health Plan shall make the updated Provider Policies and Procedures Manual available to Health Plan staff, IDHW, and Providers within five (5) business days of IDHW acceptance.

3. Include, but not be limited to:

a) Policies and procedures;

b) Policies and procedures for the implementation of all aspects of the LTSS program;

c) Covered Services and limitations;

d) Claims filing instructions, including detailed information on how to submit a clean claim;

e) Criteria and process to use when requesting prior authorizations;

f) Definition and requirements pertaining to urgent and emergent care;

g) Enrollees' rights;

h) Providers' rights for advising or advocating on behalf of his or her patient;

i) Provider non-discrimination information;

j) Policies and procedures for Grievances and Appeals in accordance with 42 CFR § 438.414;

k) Information on outreach services;

l) Frequently asked questions and answers; and

m) Health Plan and IDHW contact information including addresses and phone numbers.

H. Provider Education Activities: The Health Plan shall provide ongoing education to Providers regarding the contracted services as well as Health Plan-specific policies and procedures. The Health Plan shall:

1. Develop Provider education and outreach materials;

2. Participate in IDHW-sponsored Provider outreach activities upon request.

3. Include, but not be limited to the following topics for education:

a) Prior authorization policies and procedures;

b) Clinical protocols;

c) Enrollees' rights and responsibilities;

d) Claims dispute resolution procedures;

e) Pay-for-performance and other physician incentive programs;

f) Enrollee co-pay and cost-sharing responsibilities; and

g) Training on how to submit a clean claim.

(1) Training shall be offered to all Providers prior to implementation.

(2) Copies of the IDHW-approved Provider Policy and Procedures Manual must be available to Providers at the time of training.

4. Ensure there is a staff person responsible for educating and assisting Providers regarding appropriate claims submission processes and requirements; coding updates; electronic claims transactions and electronic funds transfer; the development and

maintenance of Health Plan resources such as Provider manuals, website, fee schedules, etc.; technical assistance regarding claims submission and resolution processes; and prompt resolution of claims issues or inquiries.

XXXIII. Customer Service System

A. The Health Plan shall implement and maintain a customer service system that includes implementation of a Customer Service Plan. The Customer Service Plan must be approved by IDHW and shall include the following requirements:

1. Operate an Enrollee Services Department staffed with trained representatives;
2. Comply with the requirements at 42 CFR § 438.10(f)(6) by ensuring required information is accessible and readily available to Enrollees.
3. Customer service policies and training for staff;
4. Implement and maintain a Call Center/Help Desk that meets the requirements in Attachment 10 - Information Systems;
5. Implement and maintain an internet website for Enrollees to access information pertaining to the Health Plan's services that complies with the requirements in Attachment 10 - Information Systems;
6. Implement and maintain an internet website for Providers that complies with the requirements in Attachment 10 - Information Systems; and
7. Operate a dedicated toll-free Provider Services Helpline that complies with the requirements in Attachment 10 - Information Systems and is staffed with trained representatives knowledgeable about the contracted services.
8. If Interactive Voice Response (IVR) is utilized, comply with the requirements in Attachment 11 - Provider Helpline, Call Center, and IVR Requirements.
9. Conduct periodic (at least annually) monitoring of calls to the Call Center/Help Desk and for QM purposes.

XXXIV. Critical Incident Resolution and Tracking System

A. The Health Plan shall implement and maintain a Critical Incident Resolution and Tracking System for all Critical Incidents. The system shall include safeguards to prevent abuse, neglect and exploitation. The Health Plan shall have a system in place allowing network Providers and/or Health Plan staff to document incidents of health and safety issues impacting an Enrollee. The Health Plan shall:

B. Implement and maintain policies and procedures for resolving and tracking Critical Incidents.

1. Critical Incident Process: The following must be included in the Health Plan's Critical Incident procedures:
   a) The Health Plan and its network Providers shall abide by Idaho State law including those laws regarding mandatory reporting.
   b) Critical Incidents shall be logged by a network Provider, or the Health Plan itself, when a Critical Incident is either observed or noted.

c) Designate a network Provider or Health Plan staff to conduct a reasonable investigation or inquiry into the Critical Incident logged and give due consideration and deliberation to all information submitted by or on behalf of the Enrollee.

d) Designee shall resolve each Critical Incident report by documenting at a minimum:

(1) A summary of the Critical Incident including a statement of the issues raised and pertinent facts determined by the investigation;

(2) A statement of the specific coverage, policy, or procedure provisions that apply; and

(3) A decision or resolution of the Critical Incident including a reasoned statement explaining the basis for the decision or resolution.

C. Include components that allow the Health Plan to analyze the Critical Incident and provide reports as requested by the IDHW in Critical Incident Resolution and Tracking System.

D. Comply with Idaho Code § 39-53, "Adult Abuse, Neglect and Exploitation Act" in all aspects of its Critical Incident Resolution and Tracking System.

E. Have internal controls to monitor the operation of the Critical Incident Resolution and Tracking System.

F. Track all Critical Incidents, whether they are resolved or in the process of resolution, and report the information to the IDHW.

G. Analyze the Critical Incidents and utilize the information to improve business practices.

H. Have a methodology for reviewing and resolving Critical Incidents received, including timelines for the process.

I. Address Critical Incidents that may need resolution at the IDHW level.

J. Ensure that all documents pertaining to Critical Incident investigations and resolutions are preserved in an orderly and accessible manner.

K. Respond to Critical Incidents within twenty-four (24) hours based on the following criteria:

1. Reports of abuse, neglect, or exploitation shall be reported immediately to Adult/Child Protection and to the appropriate law enforcement agency within four (4) hours;

2. A report of any Critical Incident that may impact the health and/or safety of an Enrollee must be responded to as appropriate to ensure the health and safety of the Enrollee; and

3. May result in an interim resolution/response until a permanent resolution/response can be accomplished.

XXXV. Grievances and Appeals

A. The Health Plan shall implement and maintain a system for Enrollees meeting all regulation requirements, including a grievance process, an appeal process, and access to the

IDHW fair hearing system, which complies with 42 CFR § 438.400-424, and allows any Enrollee the opportunity to challenge the Health Plan's Action(s) related to any Covered Service.

B. The Health Plan's Grievances and Appeals System shall include a grievance process, an appeal process, and access to the IDHW fair hearing system. The Grievances and Appeals System requirements apply to all three components of the grievance system. The Grievances and Appeals System shall include the following provisions:

1. Filing Procedures
   a) An Enrollee may file a Grievance or a Health Plan level Appeal.
   b) An Enrollee may be represented by legal counsel at their own expense, or by a representative of the Enrollee's choosing. The Enrollee must sign a written statement indicating his or her choice for a Provider to be the Enrollee's representative before the provider will be permitted to assume that role.
   c) The Enrollee or the Enrollee's representative may file a Grievance or an Appeal either orally or in writing, with the Health Plan or IDHW. If filed with IDHW, the Grievance or Appeal will be forwarded to the Health Plan. If the grievance or appeal is regarding an IDHW action impacting the Enrollee, IDHW will route the grievance or appeal through the State Fair Hearing process and notify the Health Plan of the outcome.
   d) Unless the Enrollee or the Enrollee's representative requests expedited resolution, an oral request for an Appeal must be followed by a written request.
2. Timing: The Enrollee or the Enrollee's representative has sixty (60) calendar days from the date the Notice of Action was mailed to file an Appeal. A Grievance may be filed at any time.
3. Notice of Action: The Health Plan's policies and procedures shall include the following requirements for notifying Enrollees and Providers of Action(s) the Health Plan has taken or intends to take that negatively affects eligibility or services.
   a) The Notice must be in writing and must meet the language requirements of 42 CFR § 438.10(c) and (d) to ensure ease of understanding.
   b) The Notice must explain the following:
      (1) The Action the Health Plan has taken or intends to take;
      (2) The reasons for the Action and the applicable rules, state or federal, that support the Action;
      (3) The rights of the Enrollee or Provider to file an appeal and procedures for exercising Health Plan level Appeal rights;
      (4) The Enrollee's right to represent himself or herself or be represented by a person of his or her choosing;
      (5) The Enrollee's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

(6) The circumstances under which expedited resolution is available and how to request it; and

(7) The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee will be required to pay the costs of these service.

(8) That the rules governing the state's fair hearing system, which is available to an Enrollee who exhausts appeal rights with the Health Plan, are found in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."

c) A copy of the Notice of Action must be maintained in the Enrollee file.

4. Timing of Notice of Action: The Health Plan shall mail the notice within the following timeframes:

a) For termination, suspension, or reduction of previously authorized Covered Services, at least 10 days before the date of action. In the event of verified probable recipient fraud, the period of advance notice is shortened to 5 days. Notice shall be given by the date of the action for the following, pursuant to in 42 CFR § 431.211, § 431.213, and § 431.214:

(1) The death of an Enrollee

(2) A signed Enrollee statement requesting service termination or providing information that requires the termination or reduction of services

(3) The Enrollee's address is unknown and mail directed to the Enrollee has no forwarding address

(4) The Enrollee has been accepted for Medicaid services by another local jurisdiction

(5) The Enrollee's physician prescribes a change in level of medical care

(6) The safety or health of the Enrollee would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, or an immediate transfer is required by the Enrollee's urgent medical needs.

b) For denial of payment, at the time of any action affecting the claim.

c) For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR § 438.210(d)(1).

d) If the Health Plan extends the timeframe in accordance with 42 CFR § 438.210(d)(1), it shall:

(1) Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and

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

e) For service authorization decisions not reached within the timeframes specified in 42 CFR § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

f) For expedited service authorization decisions, within the timeframes specified in 42 CFR § 438.210(d).

5. Handling of Grievances and Appeals: The Health Plan's policies and procedures for handling Grievances and Appeals shall include the following requirements:

a) The Health Plan shall provide the information specified at 42 CFR § 438.10(g)(1) about the Grievance and Appeals system to all Providers and subcontractors at the time they enter into a contract.

b) The Health Plan shall give Enrollees any reasonable assistance in completing forms and taking other procedural steps including, but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

c) The Health Plan shall acknowledge receipt of each Grievance and Appeal.

d) The Health Plan shall ensure that individuals who make decisions on Grievances and Appeals are individuals who:

(1) Were not involved in any previous level of review or decision-making; and

(2) Are health care professionals who have the appropriate clinical expertise in treating the Enrollee's condition or disease, as determined by IDHW, when deciding an Appeal of a denial that is based on Medical Necessity or lack thereof, or a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues.

(3) Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

e) The Health Plan's Appeal Process shall:

(1) Provide that oral inquiries seeking to appeal an Action are treated as Appeals to establish the earliest possible filing date, and are confirmed in writing unless the Enrollee or the Provider requests expedited resolution;

(2) Provide the Enrollee a reasonable opportunity to present evidence and testimony, and make legal and factual arguments, in person as well as in writing (the Health Plan shall inform the Enrollee of the limited time available for this in the case of expedited resolution);

(3) Provide the Enrollee and his or her representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Health Plan (or at the direction of the Health Plan) during the Appeals process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe; and

(4) Include, as parties to the Appeal, the Enrollee and his or her authorized representative, and the legal representative of a deceased Enrollee's estate, whenever applicable.

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

(1) The Health Plan shall ensure that punitive action is neither taken against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

(2) In the event the Health Plan denies a request for expedited resolution of an Appeal, the Health Plan shall transfer the Appeal to the thirty (30) calendar day timeframe for standard resolution and make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

(3) Once an Enrollee files an expedited appeal, no Enrollee follow-up is required.

g) The Health Plan shall dispose of Grievances for which there is an immediate health or safety concern as expeditiously as the Enrollee's health condition requires, and mail written notice of the disposition within two (2) business days of the disposition for Grievances received in writing. Grievances received orally may be resolved orally.

h) The Health Plan shall dispose of Grievances for which there is neither an immediate health or safety issue nor a resolution response/time frame defined in rule or law within thirty (30) days, and mail written notice of the disposition within ten (10) calendar days for Grievances received in writing. Grievances received orally may be resolved orally.

i) The Health Plan shall dispose of Grievances for which resolution/response time frames are defined in rule or law, within the time frames specified in rule or law. The Health Plan shall mail written notice of the disposition no later than two (2) business days of the disposition for Grievances received in writing. Grievances received orally may be resolved orally.

j) The Health Plan shall resolve each Appeal, and provide notice as expeditiously as the Enrollee's health condition requires, not exceeding the following timeframes:

(1) Health Plan level Appeals. Thirty (30) calendar days from the date the Health Plan receives the Appeal.

(2) Expedited Health Plan level Appeals. A maximum of three (3) business days after the Health Plan receives the Appeal.

(3) Extension of timeframes. Health Plan may extend the timeframes for Health Plan level Appeals and Grievances by up to fourteen (14) calendar days if the Enrollee requests the extension, or if the Health Plan shows that there is a need for additional information and the delay is in the Enrollee's interest.

k) Requirements following extension. If the Health Plan extends the timeframe, it must complete all of the following:

(1) Make reasonable efforts to give the Enrollee prompt oral notice of the delay,

(2) Within two (2) calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision, and

(3) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

l) Notice of Grievance dispositions for Grievances received in writing shall be provided to the affected parties in writing in a manner that meets, at minimum, the standards described at 42 CFR § 438.10. The notice must include:

(1) A statement of the Grievance issue(s);

(2) A summary of the facts asserted by each party;

(3) The Health Plan decision supported by a well-reasoned statement that explains how the decision was reached; and

(4) The date of the decision.

m) For all Appeals, the Health Plan shall provide written notice of the disposition in a format and language that, at minimum meet the standards described at 42 CFR § 438.10. The notice must include:

(1) A statement of the issue(s) on Appeal;

(2) A summary of the facts asserted by each party;

(3) The Health Plan's decision supported by a well-reasoned statement that explains how the decision was reached; and

(4) The date of the decision.

n) For Appeals not resolved in favor of the Enrollee, the Health Plan's disposition notice shall also include:

(1) The right to request a State fair hearing and instruction on how to do so;

(2) The right to request to receive benefits while the hearing is pending, and instruction on how to make the request; and

(3) Notice that the Enrollee will be held liable for the cost of those benefits if the State fair hearing decision upholds the Health Plan's action.

6. Continuation of Benefits While Health Plan Appeal and State Fair Hearing are Pending:

a) Timely filing. Health Plan's policies and procedures shall define "timely filing" for purposes of this Section as on or before the later of the following:

(1) Within ten (10) calendar days of the Health Plan mailing the Notice of Action or

(2) The intended effective date of the Health Plan's proposed action.

b) Continuation of benefits. The Health Plan shall continue the Enrollee's benefits if:

(1) The Enrollee or the Enrollee's authorized representative files the Appeal in a timely manner;

(2) The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(3) The services were ordered by an authorized Provider;

(4) The original period covered by the original authorization has not expired; and

(5) The Enrollee requests extension of benefits.

7. Duration of Continued or Reinstated Benefits: If, at the Enrollee's request, the Health Plan continues or reinstates the Enrollee's benefits while the Appeal is pending, the benefits must be continued until one (1) of the following occurs:

a) The Enrollee withdraws the Appeal;

b) Ten (10) calendar days pass after the Health Plan mails the notice, providing the resolution of the Appeal against the Enrollee, unless the Enrollee, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached;

c) A State fair hearing office issues a hearing decision adverse to the Enrollee; or

d) The expiration or service limits of a previously authorized service is met.

8. Enrollee Responsibility For Services Furnished While the Appeal Is Pending. The Health Plan shall have a system in place to recover the cost of services furnished to the Enrollee if the final resolution of the Appeal is adverse to the Enrollee and benefits were continued pending Appeal to the extent they were continued solely by reason of this Section and in accordance with 42 CFR 438.420(d).

9. Miscellaneous Requirements

a) In all aspects of the Grievances and Appeals system, the Health Plan must comply with Idaho Code § 39-53, "Adult Abuse, Neglect and Exploitation Act."

b) The Health Plan shall train staff with regard to the IDHW fair hearing process, including compliance with the IDHW's "Rules Governing Contested Case Proceedings and Declaratory Rules" at IDAPA 16.05.03.

c) Information Regarding the Grievance and Appeals System. The Health Plan shall provide the information specified in this Section regarding the Grievances and Appeals system to all Providers and subcontractors. Information on how to file a Grievance or Appeal must be provided to the Enrollee at enrollment and annually thereafter.

d) Recordkeeping and Reporting Requirements. The Health Plan shall maintain records of Grievances and Appeals and shall review the information for quality assurance purposes. The Health Plan shall submit a detailed report on all Grievances and Appeals to the Contract Monitor monthly. The Health Plan's records must be accurately maintained in a manner accessible to the IDHW and available upon request to CMS.

e) The contract shall ensure that Enrollees are advised of where they can get help with reporting elder abuse/neglect/exploitation or where to report Medicaid fraud on the IDHW website at: http://healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx.

f) Effect of Reversed Appeal Resolutions.

(1) If the Health Plan or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Health Plan shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

(2) If the Health Plan or the State fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, the Health Plan must pay for those services.

g) Requirements for State fair hearings.

(1) Availability. IDHW permits the Enrollee to request a State fair hearing within one hundred twenty (120) calendar days of the Enrollee's exhaustion of the Health Plan level Appeal procedures, from the date of the Health Plan's notice of resolution.

(2) Deemed exhaustion of appeals processes. In the event that the Health Plan fails to adhere to the notice and timing requirements in this section, the Enrollee is deemed to have exhausted the Health Plan's appeals process, and the Enrollee may initiate a State fair hearing.

(3) Parties. The parties to the State fair hearing include the Health Plan as well as the Enrollee and his or her authorized representative or the representative of a deceased Enrollee's estate.

h) The Health Plan shall log all appeals and grievances in an IDHW-approved database such that the IDHW may have access to real-time data regarding grievances and appeals filed with the Health Plan.

XXXVI. Quality Management/Quality Improvement Program

A. The Health Plan shall conduct performance improvement projects, including any performance improvement projects as required by the IDHW and/or CMS, in consultation with other stakeholders.

B. IDHW will utilize an External Quality Review Organization (EQRO) to conduct an annual external quality review of contract implementation, outcomes, timeliness of, and access to, the services covered under the contract.

1. The Health Plan shall cooperate fully in any quality reviews conducted by an EQRO.

C. The Health Plan shall develop a QM/QI program and implement and maintain a written comprehensive QM/QI Plan that clearly defines its quality improvement structures and processes and assigns QM/QI responsibilities to qualified individuals. The QM/QI Plan must include the following:

1. A process to immediately remediate all individual findings identified through its monitoring process;
2. A process to track and trend all individual findings;
3. A process to identify systemic issues of poor performance and/or non-compliance;
4. A process to implement remediation and strategies to improve processes and resolve areas of non-compliance; and
5. A process to measure the success of remediation and strategies in addressing identified issues.

D. Quality Management: The Health Plan's QM program shall include policies and procedures that document processes or methods through which the Health Plan ensures clinical quality, access and availability of services, continuity and coordination of care, and that include all related contractual requirements.

E. Quality Improvement – The Health Plan's QI program shall include the following:

1. The formation of a Quality Assurance Program Improvement Committee which includes in-network medical, behavioral health, and long term care practitioners and Providers to establish and oversee QM/QI functions.
2. Sufficient resources (staffing, data resources, and analytical resources) to manage the QM/QI program.

3. Processes to demonstrate how the results of the QM program are used to address service delivery, Provider, and other QM issues as they are identified and to improve the quality of physical health, behavioral health, and long term care.

4. QI projects designed to achieve, through ongoing measurement and interventions, significant improvements sustained over time (expected to have a favorable effect on health outcomes) and Enrollee satisfaction in clinical and non-clinical care.

5. Measurements of QI projects which include objective quality indicators.

6. Processes to solicit feedback and recommendations from key stakeholders, Providers, subcontractors, Enrollees, families and/or guardians of Enrollees and methods for using the feedback and recommendations to improve the quality of care and system performance.

7. Implementation of system interventions to achieve improvements in quality.

8. Evaluation of the effectiveness of the system interventions.

9. Planning and initiation of activities for increasing or sustaining improvement.

10. Processes to ensure the Health Plan's compliance with the A&D Waiver assurances and reporting on performance measures required under the A&D Waiver, with a compliance focus developed in collaboration with the IDHW. This includes participation in efforts by the IDHW to prevent, detect, and remediate critical incidents consistent with assuring beneficiary health and welfare that are based on the requirements for home and community-based waiver programs under 42 CFR § 441.302(h).

11. Mechanisms to evaluate efficiency and appropriateness of service delivery including the quality and appropriateness of care furnished to Enrollees with special health care needs and Enrollees receiving long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Enrollee's ICP.

12. Ensuring reports related to QI projects are submitted to IDHW quarterly, and as requested.

13. Ensuring QI projects are completed in a reasonable time period to allow information on the success of QI projects in aggregate to produce new information on quality of care every year.

a) The Health Plan must have in place, at minimum, one clinical and one non-clinical QI project at any given time.

b) All proposed QI projects must be approved by the IDHW.

c) The Health Plan must report on the status of each QI project on a quarterly basis.

XXXVII. Utilization Management (UM) Program

A. The Health Plan shall operate and maintain a UM program that supports the QM/QI program. The UM program description, work plan, and program evaluation shall be exclusive to

IDHW and shall not contain documentation from other state Medicaid programs or product lines operated by the Health Plan. The UM program description, associated work plan, and annual evaluation of the UM program shall be submitted to IDHW for approval prior to implementation and include the following requirements:

1. Ensure staffing includes a designated senior physician, a behavioral health care clinician designated by the Medical Director for the implementation of behavioral health aspects of the program, and a long-term care professional designated by the Medical Director for the implementation of the long-term care aspects of the program.
2. All UM staff shall:
    a) Be in compliance with all applicable federal and State statutes and regulations and professional licensing requirements.
    b) Have a minimum of two (2) years of experience in managed care, peer review activities, or both.
    c) Not have had any disciplinary actions or other type of sanction taken against them, in any state or territory, by the relevant professional licensing or oversight board, Medicare, or Medicaid programs.
    d) Not have any legal sanctions relating to his or her professional practice including, but not limited to malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by IDHW.
    e) Have sufficient clinical expertise and training to interpret and apply the UM criteria and UM practice guidelines.
    f) Receive ongoing training regarding interpretation and application of the UM practice guidelines.
3. Use appropriately licensed professionals to supervise all Medical Necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making.
4. Ensure that compensation to individuals or entities conducting UM activities is not structured to incentivize the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee. 42 CFR § 438.6(h), 42 CFR § 422.208 and 422.210
5. Have in place policies, procedures, and systems that at a minimum:
    a) Identify instances of over- and under-utilization of MLTSS services;
    b) Identify aberrant provider practice patterns
    c) Identify critical quality of care issues;
    d) Ensure requests for initial and continuing authorizations of services are processed per 42 CFR § 438.210(b) and include mechanisms to ensure consistent application of review criteria for authorization decisions and ensure consultation with the Provider requesting pre-authorization of service, when appropriate; and
    e) Ensure any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a physical health or behavioral health care professional who has

appropriate clinical expertise in treating the Enrollee's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

6. Link Enrollees to disease management and care coordination.

7. Encourage health literacy and informed healthcare decisions.

8. Identify and address barriers that may inhibit Enrollees' abilities to maintain healthy lifestyles such as obtaining preventive care and successful participation in drug maintenance programs.

9. Utilize UM data to identify additional disease management programs that are needed.

10. Monitor access to preventive care, to the extent possible, specifically to identify Enrollees who are not accessing preventive care services in accordance with industry accepted preventive care standards and IDHW recommended preventive care guidelines with a focus on Enrollees with special needs, diagnoses of severe mental illness, or substance abuse.

11. Develop education, incentive, and outreach plans to increase Enrollee compliance with preventive care standards.

12. Establish UM practice guidelines in accordance with 42 CFR § 438.236 based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field that ensure decisions for UM, Enrollee education, and coverage of services are applied in accordance with these guidelines. The Health Plan's UM practice guidelines shall:

a) Consider the needs of Enrollees.

b) Be adopted in consultation with Providers.

c) Be reviewed and updated as appropriate.

d) Be disseminated to all affected Providers, and upon request to Enrollees and Potential Enrollees in a manner that is accessible and understandable.

e) Meet all standards of the Health Plan's accrediting entity.

f) Include and provide timeframes for the following requirements:

(1) Complete initial requests for prior authorization of services;

(2) Complete initial determinations of Medical Necessity;

(3) Complete Provider and Enrollee appeals and expedited appeals for prior authorization of service requests or determinations of Medical Necessity, per state law and in accordance with the Grievances and Appeals Section;

(4) Notify Providers and Enrollees in writing of the Health Plan's decisions on initial prior authorization requests and determinations of Medical Necessity;

(5) Notify Providers and Enrollees of the Health Plan's decisions on appeals and expedited appeals of prior authorization requests and determinations of Medical Necessity;

(6) Routinely assess the effectiveness and the efficiency of the UM program;

(7) Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, behavioral health treatments, and pharmacy formularies and devices;

(8) Target areas of suspected inappropriate service utilization;

(9) Detect over and under-utilization of emergency room services and other services;

(10) Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

(11) Compare Enrollee and Provider utilization with norms for comparable Enrollees and in-network Providers;

(12) Routinely monitor inpatient admissions, emergency room use, ancillary, out of area services, and out-of-network services, as well as behavioral health inpatient and outpatient services;

(13) Ensure that treatment and Discharge Planning are addressed at the time of authorization and concurrent review, other Providers, and other supports identified by the Enrollee as appropriate;

(14) Maintain distinct policies and procedures regarding long-term care services;

(15) Document access to Board Certified Healthcare Professionals to assist in making Medical Necessity determinations;

(16) Refer suspected cases of Provider or Enrollee Fraud or Abuse to IDHW;

(17) Identify aberrant Provider practice patterns (especially related to emergency room, impatient services, and drug utilization); and

(18) Identify critical quality of care issues.

13. Provide and implement a UM Work Plan that includes but is not limited to the following activities:

a) Referrals and coordination of Covered Services.

b) Authorization of Covered Services, including modification or denial of requests for such services.

c) Assistance to Providers to effectively provide inpatient Discharge Planning.

d) Behavioral health treatment and Discharge Planning.

e) Monitor and ensure the appropriate utilization of specialty services, including behavioral health services.

f) Provide training and supervision to the Health Plan's UM clinical staff and Providers on:

(1) The standard application of Medical Necessity criteria and UM policies and procedures; and

(2) UM policies, practices, and data reported to the Health Plan to ensure that it is standardized across all Providers within the Network.

g) The consistent application and implementation of the Health Plan's clinical criteria and guidelines including the behavioral health clinical criteria approved by IDHW.

h) Monitor and assess all Health Plan services and outcomes measurement, using any standardized clinical outcomes measurement tools to support UM activities.

i) Access, collect, and analyze behavioral health and long-term care services for quality management and Network Adequacy purposes.

j) Monitor utilization through retrospective reviews to:

(1) Identify areas of high and low utilization and key reasons for these patterns;

(2) Assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care; and

(3) Identify utilization patterns of all Providers by significant data elements and established outlier criteria for all services.

k) Ensure the services furnished by Providers were appropriate and Medically Necessary, authorized, and billed in accordance with the Health Plan's requirements. This includes monthly review of a random sample of no fewer than two and one-half percent (2 1/2 %) of Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees.

l) Monitor issues regarding quality and access to services identified by the Health Plan, IDHW, Enrollees, and Providers, including the tracking of these issues and resolutions.

m) Report Medical Necessity determination decisions at an aggregate level.

n) For A&D Waiver services and PCS, ensure authorization of at least the level of service required by the UAI.

o) Assess Provider/office staff satisfaction with UM processes to identify areas for improvement as part of the Provider survey as described in the Reports Section.

B. The Health Plan shall have a UM committee directed by the Health Plan's Medical Director. The committee shall:

1. Monitor Providers' requests for rendering health care services to its Enrollees;

2. Monitor the medical appropriateness and necessity of Covered Services provided to Enrollees;

3. Review the effectiveness of the utilization review process and make changes to the process as needed;

4. Write policies and procedures for UM that conform to industry standards including methods, timelines, and members responsible for completing each task;

5. Confirm the Health Plan has an effective mechanism in place for an in-network Provider or Health Plan representative to respond within one (1) hour to all emergency room Providers twenty-four (24) hours per day, seven (7) days per week:

a) After an Enrollee's initial emergency room screening; and

b) After an Enrollee has been stabilized and the emergency room Provider considers continued treatment necessary to maintain stabilization.

XXXVIII. Incentive Programs

A. IDHW reserves the right to implement a pay for performance program to reward the Health Plan's effort to improve quality and outcomes.

1. Potential incentive programs to be developed may include but are not limited to, capitation withholds and/or bonus payments based on performance targets in priority areas established by IDHW. IDHW will provide advance notice prior to implementation of such programs.

B. Provider Incentive Programs: The Health Plan may establish a performance-based incentive system including a physician incentive plan for Providers using its own methodology that complies with all federal regulations regarding physician incentive plans and provide IDHW information on its plan as required in the regulations with sufficient detail to permit IDHW to determine whether the incentive plan complies with the federal requirements. The Health Plan shall:

1. Obtain IDHW approval prior to implementing any Provider incentives and before making any changes to an approved incentive. IDHW encourages creativity in designing incentive programs that encourage positive Enrollee engagement and health outcomes.

2. Comply with the requirements set forth at 42 CFR § 422.208 and 42 CFR § 422.210 regarding physician incentive plans in accordance with 42 CFR § 438.6(h) by reporting the following:

a) Whether services not furnished by the physician or group are covered by the incentive plan.

b) The type of incentive arrangements and percent of withhold or bonus (if applicable).

c) Panel size, and if patients are pooled, the approved method used

d) Proof the physician or group has adequate stop loss coverage, including amount and type of stop loss if the physician or group is at substantial financial risk.

3. Not make incentive arrangements include any payment or other inducement that serves to withhold, limit, or reduce necessary medical or non-medical Covered Services to Enrollees.

4. Ensure that physicians or physician groups have either aggregate or per-patient stop-loss protection and conduct annual enrollee surveys if the physician incentive plan places a physician or physician group at substantial financial risk in accordance with 42 CFR § 422.208(d).

5. Provide adequate and timely information concerning its physician incentive plan, upon request, to its Enrollees and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations.

6. Ensure that incentive programs are
   a) For a fixed period of time;
   b) Not renewed automatically;
   c) Made available to both public and private contractors;
   d) Not conditioned on intergovernmental transfer agreements; and
   e) Necessary for the specified activities and targets.

7. Enrollee Incentive Programs: The Health Plan may establish Enrollee incentive programs to encourage appropriate utilization of health services and healthy behaviors using its own methodology. Enrollee incentives may be financial or nonfinancial. The Health Plan shall:

8. Obtain IDHW approval prior to implementing any Enrollee incentives and before making any changes to an approved incentive.

9. Ensure that in any Enrollee incentive program, the incentives are tied to appropriate utilization of health services and/or healthy behaviors. For example, the Enrollee incentive programs can encourage responsible emergency room use or adhering to prescribed drug maintenance programs. The Health Plan should develop Enrollee incentives to encourage appropriate utilization of health care services, improve adherence to keeping appointments, and increase the receipt of health care services in the appropriate treatment setting.

10. Comply with all marketing provisions in 42 CFR § 438.104, federal and State statutes, and regulations regarding inducements.

XXXIX. Health Information Technology (HIT)

A. The Health Plan may develop and utilize HIT initiatives to improve quality of care and/or reduce overall health care costs. Any HIT initiative must be approved by IDHW prior to implementation, and IDHW may require the implementation of HIT initiatives during the term of the contract. HIT initiatives may include:

1. Electronic health record (EHR) that focuses on the total health of the patient, going beyond standard clinical data collected in the Provider's office and inclusive of a broader view on a patient's care that allows electronic data transmission and data sharing;

2. Electronic prescribing (E-prescribing) that may include electronic access to clinical decision support information and integration with an EHR;

3. Benchmarking that may include pooling data from multiple Providers and "benchmarking" or comparing metrics related to outcomes, utilization of services, and populations; and

4. Telehealth technology that may include applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications

technology to facilitate Provider-to-Provider consultations and Provider-to-Enrollee live interactions.

5. The Health Plan shall:

6. Disclose the current or planned relationship between the Health Plan and the Idaho Health Data Exchange (IHDE) and include the IHDE in HIT initiatives, as appropriate.

7. Ensure any HIT or HIT-related processes support national, state, and regional standards for health information exchange and interoperability.

a) Baseline documentation shall include policies and procedures for monitoring the standards for health information exchange and interoperability.

XL. Electronic Health Records

A. The Health Plan may assist Network Providers in implementing the use of EHR in their practice. The Health Plan may assist Providers in:

1. Developing goals for the use of EHR;

2. Conducting a readiness assessment including, but not limited to the following areas:

a) Organizational culture,

b) Management and leadership,

c) Operational,

d) Technical, and

e) Development of a plan for EHR implementation;

3. Reviewing and documenting existing workflows, including how information contained in medical records is created, maintained, and exchanged;

4. Identifying business process changes and specific inefficiencies to be corrected prior to EHR implementation;

5. Determining the most efficient and effective way to convert existing data;

6. Identifying other systems requiring integration, if any;

7. Workflow re-design activities, including clinic policies and procedures, job descriptions, and scheduling and billing workflows;

8. Understanding and documenting total costs related to EHR implementation;

9. Documenting Provider or practice requirements for the EHR system, including registry functionality and report generation capability;

10. Ensuring the reporting functionality includes:

a) Identification of a subpopulation of Enrollees,

b) Viewing and manipulation of data,

c) Exporting data,

d) Creating notifications for Enrollees and Providers, and

e) Tracking quality measures;

11. Ensuring EHRs used by Providers meet the Commission for Certification for Health Information Technology (CCHIT) 2011 Behavioral Health EHR Certification Criteria

and EHRs used by eligible Providers meet the certification criteria regulations of 45 CFR § 170;

12. Ensuring EHRs used by Providers can interface with the IHDE;

13. Achieving meaningful use of the EHR system and qualifying for the Medicare or Medicaid Meaningful Use incentives; and

14. Ensuring policies and procedures are in place to ensure compliance with HIPAA privacy and security regulations.

XLI. Fraud and Abuse

A. The Health Plan shall implement and maintain surveillance and utilization control programs and procedures in accordance with 42 CFR § 456.3, § 456.4, and § 456.23 to safeguard against unnecessary or inappropriate use of services and improper payments. The Health Plan shall:

1. Have internal controls, policies, and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

2. Have a mechanism to verify, by sampling or other methods, whether services that have been delivered by network providers were received by Enrollees and the application of such verification processes on a routine basis. The Health Plan shall have in place a process to expand an audit when instances of billing for services not rendered are validated.

3. Comply with all federal and State statutes and regulations regarding fraud and abuse, including, but not limited to § 1128, § 1156, and § 1902(a)(68) of the Social Security Act "Reporting and Investigating Suspected Fraud and Abuse."

4. Provide adequate staffing and resources to investigate detected offenses; and for the development and implementation of corrective action plans relating to the contracted services.

5. Have methods for identification, investigation, and referral of suspected fraud cases.

6. Report all tips and confirmed or suspected fraud and abuse to IDHW and MFCU within IDHW-specified timeframes.

7. Investigate all incidents of suspected and/or confirmed fraud and abuse.

8. Notify IDHW when the Health Plan denies a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of a Provider to provide contracted services for program integrity reasons.

9. Make full disclosure of ownership and control information for the Health Plan and any subcontracting entities, Providers, and business transactions in accordance with 42 CFR § 455.100 – 106 and IDAPA 16.03.09, including any time there is a change to any of the information on the disclosure form and at any time upon request.

10. Provide written disclosure of any prohibited affiliation of the Health Plan or its principals, or of any subcontracting entities or Providers, of any prohibited affiliation under 42 CFR § 438.610.

11. Comply with all federal requirements in accordance with 42 CFR § 1002 on exclusion and debarment screening using both the System for Award Management (SAM) https://www.sam.gov and the DHHS-OIG List of Excluded Enrollees/Entities (LEIE) http://oig.hhs.gov/exclusions/exclusions_list.asp; ensuring all tax-reporting provider entities, including their owners and employees, that bill and/or receive IDHW funds as the result of this contract are screened against the federal exclusion databases.

12. Not make payment for a service furnished by an individual or entity when there is a pending investigation of a credible allegation of fraud against the individual or entity. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by IDHW and/or the Health Plan dependent upon the entity that identifies the payment of unallowable funds to excluded individuals, with the exception of the provision of emergency services.

13. Report overpayments made by IDHW to the Health Plan and overpayments made by the Health Plan to a Provider.

a) The Health Plan is entitled to retain recoveries of overpayments to network providers related to fraud, waste, and abuse.

(1) The IDHW has the right to audit and recover identified overpayments and assess penalties after twelve (12) months from the date of service. Overpayments and penalties will be recovered from the Health Plan.

b) The Health Plan must report recoveries of overpayments to network providers as specified in the Reports Section.

14. Have a mechanism for network providers to report receipt of overpayments, to return overpayments within sixty (60) days after the date on which the overpayment was investigated, and to notify the Health Plan in writing of the reason for the overpayment.

15. Except as provided in 42 CFR §455.19, ensure all Provider claims forms are imprinted in boldface type with the following statements, or with alternate wording that is approved by IDHW and the Regional CMS Administrator. The statements may be printed above the claimant's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the claimant's signature.

a) "This is to certify that the foregoing information is true, accurate, and complete."

b) "I understand that payment of this claim will originate from federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and State laws."

16. Have a written Fraud and Abuse Compliance Plan. A paper and electronic copy of the Fraud and Abuse Compliance Plan shall be provided to IDHW Program Integrity Unit within ninety (90) calendar days of the contract effective date and annually thereafter. IDHW will provide notice of approval, denial, or modification of the Fraud and Abuse Compliance Plan to the Health Plan within thirty (30) calendar days of

receipt. The Health Plan shall make any requested updates or modifications available for review to IDHW as requested by IDHW and/or the IDHW Program Integrity Unit within thirty (30) calendar days of a request. The Fraud and Abuse Compliance Plan shall include the following:

a) A risk assessment of the Health Plan's various fraud and abuse/program integrity processes that includes a listing of the Health Plan's top three (3) vulnerable areas and outlines action plans in mitigating such risks. A risk assessment shall also be submitted on an 'as needed' basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines), is issued on a Provider with concerns of fraud and abuse. The Health Plan shall inform IDHW of such action and provide details of such financial action;

b) An outline of activities for the next reporting year regarding employee education of federal and State statutes and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers, and employees know and understand the provisions of the Health Plan's Fraud and Abuse Compliance Plan;

c) An outline of activities for the next reporting year regarding Provider education of federal and State statutes and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste and on identifying and educating targeted Providers with patterns of incorrect billing practices and/or overpayments;

d) Procedures to prevent and detect abuse and fraud in the administration and delivery of services under this contract;

e) Descriptions of specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:

(1) Automated pre-payment claims edits;

(2) Automated post-payment claims edits;

(3) Desk audits on post-processing review of claims;

f) A list of reports of Provider profiling and credentialing used to aid program and payment integrity reviews;

g) Surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of services;

h) A list of provisions in the subcontractor and Network Provider Subcontracts that ensure the integrity of Provider credentials;

i) A list of references in Provider and Enrollee material regarding fraud and abuse referrals;

j) A method for confidential reporting of fraud and abuse to the designated person;

k) Methods for the prompt investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports;

l) Procedures that ensure the identities of individuals reporting violations are protected and that there is no retaliation against such persons;

m) Specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud and abuse;

n) A requirement that any confirmed or suspected Provider fraud and abuse under federal or State law be reported to the IDHW and MFCU and that Enrollee fraud and abuse is reported to the MFCU;

o) Work plans for conducting both announced and unannounced site visits and field audits to Providers defined as high risk Providers with cycle/auto billing activities and Providers offering Durable Medical Equipment (DME), home health, mental health, or non-medical transportation services; to ensure services are rendered and billed correctly;

p) Methods of ensuring compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare + Choice Organizations/Medicare Advantage plans issued by the DHHS-OIG;

q) Reporting of fraud and abuse activities as required in the Reports Section, including the number of complaints of fraud and abuse that warrant preliminary investigation. For each which warrants investigation, reporting of the Enrollee's name and identification, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case;

r) Exclusion checking that includes conducting a monthly comparison of their Provider files, including atypical Providers, against the System for Award Management (SAM) https://www.sam.gov and the DHHS-OIG List of Excluded Enrollees/Entities (LEIE) http://oig.hhs.gov/exclusions/exclusions_list.asp, and the Idaho Medicaid exclusion list located at: http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ProviderExclusionList.pdf, and providing a report of the result of comparison to IDHW each month;

s) Establishment of an electronic database to capture identifiable information on the owners, agents, and managing employees listed on Providers' Disclosure forms; and

t) Prompt termination of Providers due to inactivity in the past twelve (12) months.

17. Have a designated compliance officer and Regulatory Compliance Committee that are accountable to senior management, and have effective training and education for this committee and for the Health Plan's employees. The Regulatory Compliance Committee must be charged with overseeing the organization's compliance program and its compliance with the requirements under this contract. The Health Plan must ensure effective lines of communication between the compliance officer and the Health Plan's employees.

a) The Regulatory Compliance Committee must establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

18. Have enforcement of standards through well-publicized disciplinary guidelines.

XLII. Information Systems and Data Security

A. The Health Plan shall implement and maintain an Information Systems and Data Security Plan that includes, but is not limited to all of the requirements in Attachment 10 - Information Systems. The Health Plan shall submit the Information Systems and Data Security Plan for approval prior to implementation.

B. The Health Plan shall comply with the requirements in Attachment 10 - Information Systems; provided, however, in the event a change in a vendor is required, the IDHW and Health Plan will endeavor to work in good faith to minimize the operational and financial impact of such change.

XLIII. Claims Management System

A. The Health Plan shall maintain an IDHW approved Claims Management System to process and audit Provider claims that includes the following:

1. A system for verifying and ensuring that Providers are not submitting claims or encounter data for services that were not provided.

2. Policies and procedures to monitor the accuracy of claims adjudication that include:

a) Methods to ensure all procedures or encounters are accurately priced;

b) A method to ensure the filing deadlines for in-network Provider claims submission is included in all of the Health Plan's Network Provider Subcontracts; and

c) A filing deadline for out-of-network Provider claims submission twelve (12) months from the date of service.

3. A claims processing system that supports paper and electronic claims submission for both in and out-of-network Providers and accepts claims submitted via standard electronic data interchange (EDI) transactions directly from Providers, through a Provider's intermediary, and paper claims; that does not require out-of-network Providers to establish a Health Plan-specific Provider number to receive payment. Health Plan may accept paper claims instead of electronic, upon a demonstration of

good cause by the provider in accordance with criteria in appropriate Health Plan policies and procedures. The Health Plan's claims processing system shall:

a) Process all claim types (e.g., professional and institutional claims);

b) Uniquely identify the Provider of the service (ensuring all billing information related to tax-reporting business entities and information related to individuals who provide services are properly reported on claims);

c) Indicate the date of claim receipt by the Health Plan (the date the Health Plan receives the claim as indicated by a date-stamp);

d) Ensure accurate history of actions taken on each Provider claim (i.e., paid, denied, suspended, appealed, etc.);

e) Indicate the date of claim payment (the date of the check or other form of payment);

f) Include all data elements as required by the Health Plan and IDHW for encounter data submission;

g) Track and report service use against benefit limits in accordance with the Health Plan's methodology;

h) Run a minimum of one (1) Provider payment cycle per week, on the same day each week, as determined by the Health Plan and approved in writing by IDHW; and

i) Not employ off-system or gross adjustments when processing corrections to payment errors, unless prior written authorization is received from IDHW.

4. The capacity to coordinate benefits in accordance with 42 CFR §433, Subpart D – Third Party Liability, when an Enrollee has more than one payer. Coordination of benefits rules apply when an Enrollee enrolls in the MMCP and continues to be enrolled in his/her employer/union or spouse's group health benefits plan.

a) The Health Plan must enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process.

B. The Health Plan shall provide a hard copy Explanation of Benefits statement (EOB) on a monthly basis, at a minimum, to each Enrollee that includes:

1. Summary of all claims submissions, except dental claims, billed to the Health Plan on behalf of the Enrollee during the EOB timeframe,
2. To whom payments were sent;
3. Explanation of any charges the Health Plan did not pay, and
4. Citation of the Enrollee's appeal rights.

C. The Health Plan shall provide each Provider with a Remittance Advice (RA) via hard copy or HIPAA payment transaction, based on individual Provider preference, in conjunction with the payment cycle.

1. The RA shall:

a) Indicate the disposition for each adjudicated claim by claim type unique to each Provider and by capitated payments generated and paid by the Health Plan;

a) Include a status report with explanatory remarks related to the payment or denial of each claim including, but not limited to third party liability (TPL) data;

b) Specifically identify all information and documentation the Provider is required to submit on a partially or totally denied claim; and

D. The Health Plan shall maintain staff of qualified, medically trained, and appropriately licensed personnel, consistent with NCQA accreditation standards to perform post-payment review of claims to ensure services provided were Medically Necessary.

E. The Health Plan shall implement an IHDW approved internal claims dispute procedure that includes the following requirements:

1. Providers may file a dispute if he or she disagrees with a claim decision regarding the denial or payment of a claim;

2. A method for Providers to have disputed claims reviewed by independent reviewers who are not Health Plan employees; and

3. Systematically capture the status and resolution of all claim disputes and all associated documentation.

F. The Health Plan shall comply with the IDHW random sample audits of claims and provide all requested documentation, including but not limited to Provider claims, encounter data submissions, applicable medical records, and prior authorizations in the form, manner, and timeframe determined by IDHW.

XLIV. Prompt Payment

A. The Health Plan shall:

1. Pay Providers in accordance with the standards set forth in Idaho Code Title 41, Chapter 56, and Federal regulations at 42 CFR § 447.45(d), unless the Health Plan and Provider agree to an alternate payment schedule and method.

a) Pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt of the claim.

b) Pay or deny ninety nine percent (99%) of all clean claims within ninety (90) calendar days of receipt of the claim.

c) If the claim is a paper claim, pay or deny ninety percent (90%) of clean claims within forty-five (45) calendar days of receipt of the claim.

2. The Health Plan shall have a contingency plan to make non-claim payments to Providers in cases where claim payments cannot be made by thirty (30) calendar days of receipt of the claim for ninety percent (90%) of clean claims and ninety (90) calendar days from the receipt of the claim for ninety nine percent (99%) of clean claims.

XLV. Third Party Liability and Overpayment Safety Nets

A. IDHW will compute the capitated payments based on claims experience that includes the net of TPL collections by the Health Plan.

B. The Health Plan shall:

1. Act as the State's agent to collect TPL for all Enrollees and comply with 42 CFR § 433 Subpart D and 42 CFR § 447.20 and 42 CFR § 434.6(a)(9);

2. Provide any third-party resource information in a format and media described by IDHW; and

3. Cooperate as requested by IDHW or any IDHW cost recovery vendor.

C. Subrogation: The Health Plan shall:

1. Seek all subrogation amounts as required by federal Medicaid guidelines; and

2. Treat all subrogation recoveries collected by the Health Plan outside of the claims processing system as offsets to medical expenses for the purposes of reporting as defined in the Reports Section.

D. IDHW Recovery Efforts: IDHW will:

1. Retain any TPL identified and recovered by the State more than one hundred eighty (180) calendar days after the date of payment of a claim;

2. Initiate TPL recoveries and retain all monies derived there for claims not cost-avoided by the Health Plan;

3. Be responsible for estate recovery activities and will retain any and all funds recovered through these activities; and

4. Not consider cost sharing and patient liability responsibilities TPL.

XLVI. Cost Sharing

A. IDHW will provide the Health Plan with the amount of cost sharing, if any, that it may assess to each Enrollee.

B. The Health Plan shall:

1. Ensure that if cost sharing is required for Medicaid services, it is only to the extent that cost sharing or patient liability responsibilities are required for those services by IDHW in accordance with applicable federal and State statutes and regulations, including, but not limited to IDAPA 16.03.05, 16.03.10, and 16.03.18, and 42 CFR § 447.50 through 447.82.

2. Not require an Enrollee to participate in the cost of A&D Waiver services unless:

a) The Enrollee's eligibility for medical assistance is based on approval for, and receipt of, an A&D Waiver service; and

b) The Enrollee is eligible for Medicaid if he meets the conditions referred to under IDAPA 16.03.05, Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD), Section 787.

3. Ensure Providers or collection agencies acting on the Provider's behalf do not bill Enrollees for amounts greater than applicable cost sharing or patient liability amounts for Covered Services (i.e. balance billing), including but not limited to, services that the Health Plan has not paid for, except as permitted by IDHW rules and as described below:

a) Providers may seek payment from an Enrollee only if the services are not Covered Services and, prior to providing the services, the Provider informed the Enrollee that the services were not covered.

(1) The Provider shall inform the Enrollee of the non-covered service and have the Enrollee acknowledge the information. If the Enrollee still requests the service, the Provider shall obtain such acknowledgment in writing prior to rendering the service.

(2) Regardless of any understanding worked out between the Provider and the Enrollee regarding private payment, once the Provider bills the Health Plan for a service that has been provided, the prior arrangement with the Enrollee becomes null and void.

4. Require, as a condition of payment, that the Provider accept the amount paid by the Health Plan, or appropriate denial made by the Health Plan or, if applicable, payment by the Health Plan that is supplementary to the Enrollee's third-party payer, plus any applicable amount of cost sharing or patient liability responsibilities due from the Enrollee, as payment in full for the service.

5. Notify the Provider and require the Provider and/or collection agency to cease billing an Enrollee for amounts other than the applicable amount of cost sharing or patient liability responsibilities from the Enrollee immediately and refund any monies inappropriately collected when the Health Plan is made aware of such activities. If a Provider continues to bill an Enrollee after notification by the Health Plan, the Health Plan shall refer the situation to the Contract Monitor.

6. Ensure that the Enrollee is not held liable for the following:

a) The Health Plan's debts in the event of the Plan's insolvency.

b) The covered services provided to the Enrollee for which IDHW does not pay the Health Plan.

c) The covered services provided to the Enrollee for which IDHW or the Health Plan does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement

d) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the Health Plan provided those services directly.

XLVII. Encounter Data

A. The Health Plan shall implement and maintain policies and procedures to support encounter data reporting and submission and provide an Encounter Data Work Plan prior to implementation and update the work plan at least annually that complies with the requirements in Attachment 10 - Information Systems and the following requirements. The Health Plan shall:

1. Submit timely encounter data submissions:

a) Weekly submissions of claims finalized for the week. This includes original claim submissions paid or denied, reversed claims, adjusted claims and voided claims. Pended claims are not required;

b) Weekly submissions of financial data paid on behalf of Idaho Medicaid participants; and

c) Weekly submissions of provider related data, including existing data, new additions and changes as specified in the encounter on-boarding manual..

2. Ensure the encounter data submissions are:

a) Accurate,

b) Include all required data elements,

c) Are submitted correctly,

d) Validated that the actual services were provided, and

e) Accurately adjudicated.

3. Meet any encounter reporting requirements that are in place for Medicaid managed care organizations as may be updated from time to time to meet State and Federal reporting requirements.

4. Ensure the Health Plan's Systems generate and transmit Encounter Data files according to IDHW-approved specifications in Attachment 10 - Information Systems and the Encounter On-boarding Manual, and as updated from time to time, at no cost to IDHW.

5. Maintain processes to ensure the validity, accuracy, and completeness of the encounter data, including any sub-capitation encounter data, in accordance with the standards specified in this section. IDHW will provide technical assistance to the Health Plan for developing the capacity to meet encounter reporting requirements.

6. Collect and maintain encounter data for all Covered Services provided to Enrollees.

7. Produce encounter data in an electronic format that adheres to IDHW-approved data specifications for content, content definitions, format, file structure, and data quality in Attachment 10 - Information Systems. IDHW may require the Health Plan to make revisions and updates as required by federal or State statute and regulations at the Health Plan's expense.

8. Submit a minimum of one (1) batch of encounter data to IDHW's designated agent for all paid and denied claims before 6:00 a.m. MT on Saturday of each week via SFTP.

9. Upon determination by IDHW, submit a corrective action plan and abide by non-compliance remedies as described in Special Terms and Conditions Section for failure to comply with the encounter data submission and accuracy requirements.

XLVIII. Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization Requirements

A. The Health Plan shall provide the most current SOC 1 report prepared in accordance with Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. If one is not prepared, the Health Plan shall provide a copy after the first year of operations and annually thereafter.

XLIX. Provider Preventable Conditions

A. The Health Plan shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions as identified in the Idaho State Plan. Such policies and procedures shall be in accordance with 42 CFR § 434.6(a)(12), and 42 CFR § 447.26 and guidance, and shall be consistent with IDHW policies, procedures, and guidance on Provider Preventable Conditions. The Health Plan's policies and procedures shall include the following requirements:

1. The Health Plan shall not pay a Provider for a Provider Preventable Condition.
2. As a condition of payment, the Health Plan shall comply with the requirements mandating Provider identification of Provider Preventable Conditions, and prohibiting payment for Provider Preventable Conditions as specified in 42 CFR § 434.6(a)(12) and §447.26;
3. Report all identified Provider Preventable Conditions in the form, format, and frequency specified by IDHW including, but not limited to any reporting requirements specified in the Reports Section.
4. The Health Plan shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.
5. The Health Plan may limit reductions in Provider payments to the extent that the following apply:
    a) The identified Provider Preventable Condition would otherwise result in an increase in payment;
    b) The Health Plan can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition;
6. The Health Plan shall ensure that non-payment for Provider Preventable Condition does not prevent access to services for the Enrollee.
7. The Health Plan shall ensure its Network Provider Subcontracts:
    a) Specify that no payment shall be made by the Health Plan to a Provider for a Provider Preventable Condition under the contract; and
    b) Require, as a condition of payment under the contract, that Providers comply with reporting requirements on Provider Preventable Conditions in

accordance with 42 CFR § 447.26(d) and as specified by the Health Plan and/or IDHW.

L. Medical Loss Ratio Settlements, Rate Review, and Payments in Future Years and Mid-Year Rate Adjustments

A. Medical Loss Ratio Settlements: The Health Plan shall meet a Medical Loss Ratio (MLR) threshold each year which regulates both the minimum and maximum amount, as a percentage of the gross Medicaid payments, that must be used for expenses either directly related to Covered Services or those which are related to Supplemental Services each year. The calculation will be performed by IDHW's actuary using a minimum of six (6) months after the end of the evaluation period to ensure sufficient runout.

1. The Health Plan shall use the federally defined MLR formula and shall not be below a MLR of eighty five percent (85%).

a) A basic MLR formula is benefits expense divided by revenue.

b) The federally defined MLR formula classifies certain administrative expenses as benefits expense for the calculation of the MLR, and also includes adjustments related to federal income tax. The general formula used can be described as (Claims + Quality Improvement Expenses) / (Premiums – Taxes and Fees). No credibility adjustment will be applied. This formula will be updated for changes in the federally defined MLR guidance.

c) The Premiums used in the MLR calculation will be adjusted for the actual population enrolled in the program. The premiums paid to the Health Plan are based on an assumed distribution among rate cells, while the actual population mix enrolled is to be used to calculate an adjusted premium amount. The difference between the premium paid and the adjusted premium amount will be paid as a settlement between the Health Plan and IDHW.

d) When the difference is greater than three percent (3%) from a target MLR of eighty eight percent (88%), a settlement calculation shall occur within seven (7) months after the close of the contract term.

(1) The Health Plan shall remit the amount by which the eighty five percent (85%) threshold exceeds the Health Plan's plan actual MLR multiplied by the total applicable revenue used in the MLR calculation of the contract as a lump sum payment to the IDHW.

(2) The IDHW's actuary will review and confirm the Health Plan submission and calculate the adjusted premiums.

2. The IDHW will remit the settlement amount by which the Health Plan's plan actual MLR exceeds the ninety one percent (91%) threshold multiplied by the total applicable revenue of the contract as a lump sum payment to the Health Plan.

a) The IDHW will not make any settlement payments when the MLR is between eighty five percent (85%) and ninety one percent (91%).

3. To the maximum extent possible, the Health Plan's methodology for calculating the MLR shall conform to prevailing regulatory requirements applicable to the other products offered by organizations operating health plans.

B. Rate Review Process: IDHW will review the Health Plan's financial reports, including any interim calculations of the federally defined MLR, encounter data, and other information to assess the ongoing financial stability of the Health Plan's plan and the appropriateness of capitation payments at a frequency no greater than each six (6) months.

1. The rate review process is a prospective adjustment to bring the capitation rates within a range of actuarial soundness which returns the MLR to a target of eighty eight percent (88%).
2. The first review will include a minimum of nine (9) months of paid claim data.

C. Payments in Future Years and Mid-Year Rate Adjustments: If statutory changes enacted after the rate development process is determined by IDHW to have a material change in the PMPM for any given contract term, IDHW will update the corresponding standardized payment rates outside of the annual rate development process.

1. A renewal rate proposal shall be provided to IDHW three (3) calendar months prior to the start of each contract term, if the contract is extended.

LI. Outpatient Drug Rebate Requirements

A. The Health Plan shall ensure that the covered outpatient drugs it dispenses are subject to the same manufacturer rebate requirements as IDHW's fee-for-service outpatient drugs. IDHW's manufacturer rebate requirements for fee-for-service outpatient drugs are available at http://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

B. The Health Plan shall provide a monthly report for rebate purposes as described in the Reports Section.

LII. Reports/Records/Documentation

A. IDHW will provide the Health Plan with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required.

B. IDHW may, at its discretion, change the content, format, or frequency of reports.

C. The Health Plan shall provide reports as described in the Reports Section. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframe in the specified format.

D. The Health Plan shall:

1. Comply with all reporting requirements;
2. Ensure reports are accurate and available within the required timelines;
3. Make changes and re-submit reports according to the time period and format required by IDHW if revisions to any reports are required by IDHW;
4. Provide additional reports both ad hoc and recurring, upon request;
5. Ensure all financial and non-financial performance data is accurate; and

6. Ensure all data is certified by the Health Plan's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to one of these employees in accordance with 42 CFR § 438.604 and 42 CFR § 438.606. The certification shall attest, based on best knowledge, information and belief the accuracy, completeness, and truthfulness of the data and documents submitted to IDHW. This certification shall be submitted concurrently with the certified data.

LIII. Reports

Report Description: Provider Network Report -- **Provider Enrollment File** –- The report shall include a list of current Medicaid-only service providers and their provider type and specialty. This report shall include providers of A&D Waiver services, Personal Care Services, behavioral health services, and non-medical transportation, in addition to Nursing Facilities and Intermediate Care Facilities for the Intellectually Disabled.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Provider Network Report – **Geographical Access Report** – The Health Plan shall summarize the number of network providers by type and specialty in each county within the geographic service area and when relevant, the percentage of Enrollees who have, a behavioral health provider within distances specified by IDHW.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Provider Network Report -- **Timeliness of Services Report** -- The Health Plan shall submit a detailed report that includes the following: (1) Results of the Health Plan's survey of Providers, sorted by the categories identified Attachment 7- Access Standards, which identifies the percent of Providers who have met the acceptable timeframe requirements identified in the Service Delivery Standards section of the attachment; (2) Any justification for providers not meeting the Access Standard requirements; (3) Trends in Providers not meeting the Access Standard requirements, i.e. areas of the state affected, provider types not meeting the standard, etc. and the Health Plan's specific plans to address these trends;

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Care Coordination Report -- **Assessment and Care Coordination Report** -- The Health Plan shall submit a summary report on the number and percent of Enrollees with initial wellness assessments completed within thirty (30), sixty (60) and ninety (90), calendar days of initial enrollment, including the name and credentials of the contract staff person completing the assessment; and the total number of enrollees assigned to each Care Specialist. This report shall include the total number of Enrollees with Individualized Care Plans as of the end of the reporting period.

This report shall also include a detailed report indicating the following data elements for each Enrollee due for an initial or annual assessment within the prior ninety (90) calendar days: (1) Enrollee name; (2) Enrollee Medicaid ID number (3) Assigned Care Specialist; (4) Enrollee's enrollment date; (5) wellness assessment due date; (6) wellness assessment completion date; (7) Date the care plan was mailed to the Enrollee; and (9) Enrollee wellness assessment status - Complete, Refused, Unable to Contact, or In Progress.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Care Coordination Report – **LTSS Enrollee Feedback Report** – The Health Plan shall utilize the Enrollee feedback data supplied by the IDHW as a basis for this report. The Health Plan shall include the following data elements for each reported instance of service delivery or community access issues: (1) Date of contact with Enrollee, (2) Details of investigation of issue, and (3) Outcome of investigation.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Provider Payment Report—**Enrollment/Capitation Payment Report** – The report shall identify any Enrollees for whom a capitation payment has not been made or if an incorrect payment has been made. This report shall be submitted on a quarterly basis, with a one (1) month lag time and is due by the end of the second (2nd) month following the reporting period. For example, for the quarter ending September 30, the report is due by the end of November and should include all data received through the end of October for the quarter ending September 30. These quarterly reports shall include all un-reconciled items until such time that IDHW notifies the Health Plan otherwise.

Report Format: Word and/or Excel or as specified in advance by IDHW

Report Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Provider Payment Report -- **Provider Payment Report** – The report shall identify: (1) The percent of electronic clean claims paid within thirty (30) calendar days of receipt of the claim; (2) percent of electronic clean claims denied within thirty (30) calendar days of receipt of the claim; (3) percent of all electronic clean claims paid within ninety (90) calendar days of receipt of the claim; (4) percent of all electronic clean claims denied within ninety (90) calendar days of receipt of the claim; (5) percent of paper clean claims paid within forty five (45) calendar days of receipt of the claim; (6) percent of paper clean claims denied within forty-five (45) calendar days of receipt of the claim; (7) percent of all paper clean claims paid within ninety (90) calendar days; (8) percent of all paper clean claims denied within ninety (90) calendar days.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Utilization Management Report - **High-Cost Claimants Report** -- The report shall identify and report the number of Enrollees who incurred non-nursing facility claims related to Medicaid benefits and services in excess of twenty-five thousand dollars ($25,000). The report shall include the Enrollee's age, sex, primary diagnosis, and amount paid by claim type for each identified Enrollee.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Utilization Management Report -- **Aged and Disabled Waiver Utilization Report** – The report shall include a summary overview that includes the number of Aged and Disabled Waiver Enrollees and Personal Care Services Enrollees, including the Enrollee's name, assigned identifiers, and secondary rate code when applicable (15). The report shall include detailed Enrollee data for Enrollees who have not received services in the last thirty (30) calendar days, including service group (i.e. in-home, Residential Assisted Living Facility, CFH); date of last long-term care service; length of time without long-term care services; and the reason/explanation why the Enrollee has not received services. Idaho Home Choice Money Follows the Person (IHCMFP) participants who are Enrollees will be identified separately for each data element described herein.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: The report will be submitted on a monthly basis with a one (1) month lag period (e.g., March information sent in the May report)

Report Description: Utilization Management Report -- **Drug Utilization Report for Rebates** -- The Health Plan shall provide a monthly report to be used for rebate purposes. This report shall include drug utilization data for all non-Part B and non-Part D drugs provided to Enrollees and must include information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees, including those drugs administered by physicians in their offices. The Health Plan shall work with the State's subcontractor to determine the required format.

Report Format: Health Plan shall work with the State's subcontractor to determine the required format.

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Utilization Management Report -- **Provider Satisfaction with Utilization Management** - The report shall include results of a survey of Provider/office staff satisfaction with utilization management processes, summarize areas identified for improvement, and include the Health Plan's responses to areas identified for improvement.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: QM/QI Report -- **Aged and Disabled Consumer Direction of HCBS Report** -- IHCMFP participants who are Enrollees shall be identified separately for each data element described herein. The report shall include current information, by month, on specified measures, which include but are not limited to the following: (1) Total number of Enrollees enrolled with the Health Plan; (2) The number and percent of Aged and Disabled Waiver Enrollees enrolled in self-direction of Home and Community Based services; and (3) The number and percent of Enrollees receiving self-directed services by type of self-directed service (companion services, skilled nursing, consultation, attendant care, homemaker services, and chore services).

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

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Report Description: QM/QI Report -- **Idaho Home Choice Money Follows the Person (IHCMFP) Participants Report** -- The report shall include the following: (1) The total number, name, and Social Security Number (SSN) of each Enrollee enrolled into IHCMFP; The date each Enrollee transitioned to the community; (2) Each Enrollee's current place of residence including physical address and type of Qualified Residence; (3) The date of the last care coordination visit to each

Enrollee; (4) Any inpatient facility stays during the quarter, including the Enrollee's name, SSN, type of Qualified Institution, dates of admission and discharge, and the reason for admission; and (5) The total number, of Enrollees disenrolled from IHCMFP during the quarter, including the name, SSN, and the reason for disenrollment for each Enrollee. Additional reporting requirements include: (1) Medicaid Statistical Information System Data (MSIS) that includes expenditures for all 1915c waivers, home health services, personal care if provided as a State Plan optional service, and HCBS spending on IHCMFP participants and spending under HCBS capitated rates programs; including expenditures for Transition Management T2022 and Transition Services T2038; (2) Total number and Enrollee name and identifier for Self Directed and Consumer Directed services; (3) Number of Enrollees transitioned from a nursing facility (4) Of Enrollees who transitioned from a nursing facility, the number and percent of Enrollees who transitioned to a community-based residential alternative facility, a residential setting where the Enrollee will be living independently, or a residential setting where the Enrollee will be living with a relative or other caregiver; (5) Of Enrollees who transitioned from a nursing facility, the number and percent of Enrollees who are still in the community, returned to a nursing facility within ninety (90) calendar days after transition, returned to a nursing facility more than ninety (90) calendar days after transition, and the number of Enrollees identified as potential candidates for transition from a nursing facility; (6) Of Enrollees identified as potential candidates for transition, the number and percent of Enrollees who were identified by referral (by type of referral, including but not limited to referral by treating physician, nursing facility, community-based organization, family, self, and other), via the Minimum Data Set, via care coordination, and by other source. The report shall include the total number of Enrollees transitioning from a Nursing Facility to the community.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: QM/QI Report – **Quality Improvement Project Status Update Report** – The Health Plan shall report the status of its current clinical and non-clinical quality improvement projects.

Report Format: Word or Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Customer Service Report/Provider Service Report — **Call Center/Help Desk Report** -- The report shall include the following data elements recorded by month: the total number of calls received during established business hours; the type of request from the caller, i.e. question, concern, grievance, in reference to what type of service, i.e. behavioral health, long term services and supports, medical care, etc.; of all calls received, what percent were

answered by a trained Enrollee Services Representative (non-recorded voice) within thirty (30) seconds or less; the abandoned call rate; and the percent of calls with an average wait time for assistance that did not exceed two (2) minutes.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Customer Service Report/Provider Service Report -- **Critical Incident Resolution Report** –

The report shall include the following data elements for each critical incident, separated by A&D participants, nursing facility residents, and others: a) Date critical incident was reported b) The priority level of the critical incident; c) The type of critical incident (abuse, neglect, exploitation, or other); c) The Enrollee name, identifier, and county of residence; d) Name of the person who submitted the critical incident (if made by a provider—must include the provider type), e) If the critical incident was received in writing or by phone, f) The date the critical incident was reported to law enforcement and/or Adult Protection, if applicable; g)Name of person responsible for investigating the incident, h) Whether or not the incident was substantiated, i) Whether a provider was terminated, sanctioned, or put on an exclusion list as a result of the incident, k) The date the incident report was closed; and l) A brief description of the disposition/resolution.

The report shall also include a summary indicating a) The total number of critical incidents received; b) The percent of critical incidents relating to abuse, neglect and exploitation; c) The timeframe for the disposition/resolution of critical incidents; and d) The number and percent of critical incidents for which the Health Plan did not meet the specified timeframe for resolution; and d) Identification of any trends regarding critical incidents and any action take to address these trends.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Customer Service Report/Provider Service Report – **Grievances and Appeals Report** – The report shall include the following data elements for all Grievances and Appeals reported to Health Plan: (1) Enrollee name; (2) Enrollee identifier; (3)Provider name (if Grievance received from provider); (4)Nature of Grievance or Appeal ; (5) Specific information surrounding the Grievance or Appeal ; (6) Date the Grievance or Appeal was received, (7) Date the Grievance or Appeal was reviewed, or, if applicable, the date a review meeting was held; (8) Parties named in the Grievance or Appeal; (9) The resolution of the Appeal or Grievance (at each level, if applicable); and (10) Date of the resolution (at each level, if applicable).

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Fraud and Abuse Report - **Involuntary Terminations and Fraud Activities Report** - The report shall identify Providers investigated or terminated due to sanctions, invalid licenses, service and billing concerns, or program integrity concerns. The report must include the provider name, NPI, tax ID or SSN; sources of referral or complaint that initiated investigation or termination; nature of referral or complaint; approximate dollar figure for claims in question; dates of audited services; number of Enrollees impacted; whether the investigation was a desk or field audit; whether the investigation was a sample audit or an audit of all billed services for the dates of service in question; current status of investigation; and findings, including overpayment amounts (if applicable) and actions taken by the Health Plan. The report shall also identify Providers terminated, those enrollees affected by the provider termination(s), and the new provider that replaced the terminated provider for each enrollee affected. This report shall include all confirmed or suspected fraud and abuse.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Financial Management Report – **TPL and Cost Avoidance Report** -- The report shall include recoveries from third party resources as well as funds for which the Health Plan does not pay a claim due to TPL coverage or Medicare coverage.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Financial Management Report – **Overpayment Recoveries Report** – The report shall include all recoveries of overpayments made to network providers. The report shall include the following data elements: (1) Date of service for overpaid claim; (2) Nature of overpayment (i.e. due to potential fraud, waste, or abuse; system error; etc.); (3) Provider to whom the overpayment was made; (4) Date the overpayment was discovered; (5) Whether the overpayment was reported by the provider; (6) Amount recovered; (7) Date overpayment was recovered; and (8) Whether the overpayment led to an investigation of potential fraudulent activity.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Financial Management Report – **Other Insurance Report** -- The report shall provide information on any Enrollees who have other insurance, including long-term care insurance. This report shall be submitted in a format and frequency described by IDHW.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Financial Management Report - **Medical Loss Ratio (MLR) Monthly Report** - The Health Plan shall report all medical expenses and complete the supporting claims lag tables. This report shall be accompanied by a letter from an actuary, who may be an employee of the Health Plan, indicating that the reports, including the estimate for incurred but not reported expenses, has been reviewed for accuracy. The Health Plan shall also file this report with its National Association of Insurance Commissioners (NAIC) filings due in March and August of each year using an accrual basis that includes incurred but not reported amounts by calendar service period that have been certified by an actuary. This report shall reconcile to NAIC filings. The Health Plan shall also reconcile the amount paid reported on the supporting claims lag tables to the amount paid for the corresponding period as reported on the Health Plan's encounter file submission.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly with cumulative year to date calculation

Report Description: Financial Management Report – **MLR Annual Report** – The Health Plan shall submit an annual report for each MLR year that includes the following: (1) Total incurred claims, (2) Expenditures on quality improving activities, (3) Expenditures related to activities compliant with 42 CFR §438.608(a)(1) through (5), (7), (8) and 42 CFR §438.608(b); (4) Non-claims costs; (5) Premium revenue; (6) Taxes, licensing and regulatory fees; (7) Methodology(ies) for allocation of expenditures; (8) Any credibility adjustment applied; (9) The calculated MLR; (10) Any remittance owed to the IDHW in accordance with Section LII. A. 1. c) (1) of this agreement; (11) A comparison of the information in this report with the SSAE, SOC 1, Type II audited financial reports also required of the Health Plan; (12) A description of the aggregation method used for total incurred claims; (13) The number of member months; and (14) An attestation to the accuracy of the calculation of the MLR and the data provided within the report.

Report Format: Word or PDF

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Claims Management Report – **Claims Payment Accuracy Report** -- The report shall include the results of the internal audit of the random sample of all paid claims and shall report on the number and percent of claims that are paid accurately. The report shall include a detail page reflecting the audit methodology and the claims submitted versus claims paid data for the claims selected in the sample. If the Health Plan subcontracts for the provision of any Covered Services, and the subcontractor is responsible for processing claims, the Health Plan shall submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report for each subcontractor shall report on the number and percent of claims that are paid accurately. This report does not include Medicare and Part D claims.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Claims Management Report – **Claims Activity Report** -- The report shall identify the number of claims received, number of claims denied (by reason), number of claims paid, number of claims pended, number of adjustments (including repayments), total dollar value of claims billed, total dollar value of claims paid by the categories of service specified by IDHW, and the average weekly payout amount of claims. This report does not include Medicare and Part D claims.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Information Systems Report -- **Systems Problem Report** -- The Health Plan shall provide a report within five (5) business days of the occurrence of a problem with system availability that includes full written documentation that includes a plan that describes how the Health Plan will prevent the problem from occurring again.

Report Format: Word and/or Excel or other formats specifically requested by IDHW

Reporting Phase: Ongoing

Report Due: Within five (5) business days of the occurrence of a problem with system availability

Report Description: Information Systems Report -- **Systems Availability and Performance Report** -- The Health Plan shall submit a monthly Systems Availability and Performance Report that provides information on availability and unavailability by major systems. Note: System availability would not include scheduled maintenance.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: Information Systems Report -- **Reporting on Controls at a Service Organization** -- An SSAE, SOC 1, Type II audit shall be performed annually and the Health Plan shall submit a copy of the audit report to IDHW upon the completion of each audit. The audit must comply with the Centers for Medicare and Medicaid Services (CMS) HIPAA Privacy and Security Rules and the CMS Medicaid Enterprise Certification Toolkit Security and Privacy Checklist an annual SSAE-16 audit. The report shall have two (2) attachments: (1) A description of the service organization's controls that may be relevant to a user organization's internal control as it relates to an audit of financial statements; and (2) A description of controls for which tests of operating effectiveness were performed, the control objectives the controls were intended to achieve, the tests applied, and the results of those tests. The Health Plan shall also file its annual audited financial report in accordance with IDAPA 18.01.62, "Annual Audited Financial Reports."

Report Format: PDF

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Information Systems Report -- **Contingency and Continuity Testing Report** -- The Health Plan shall conduct annual exercises to test current versions of information system contingency and continuity plans. The Health Plan shall provide a report on the annual exercises conducted to test current versions of information system contingency and continuity plans that includes a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

Report Description: Administrative Requirements Report -- **Activities of the Member Advisory Group** -- The report shall include the membership of the advisory group (name, address, and organization represented), a description of any orientation and/or ongoing training activities for advisory group members, and information on advisory group meetings, including the date, time, location, meeting attendees, and minutes from each meeting.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: January 31 and July 31

Report Description: Administrative Requirements Report -- **Service Denial Report** -- For all Enrollee services denied through the Health Plan, the Health Plan shall provide a report that includes the number of requests denied and the reasons for denial. The data should be reported by month and be cumulative; keeping the data for each month of the contract in the report up to a rolling thirteen (13) month data set if the contract is extended. This report does not include Medicare and Part D service denials.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Monthly

Report Description: HIPAA Report -- **Privacy/Security Incident Report** – The Health Plan shall track all security incidents as defined by HIPAA and provide a report that includes, at a minimum, the date of the incident, the date of notification to the office of the Idaho Attorney General, the nature and scope of the incident, the Health Plan's response to the incident, and the mitigating measures taken by the Health Plan to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the Health Plan's information system will not be considered a privacy/security incident for purposes of this report.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: **Non-discrimination Compliance Report** – The report shall include a listing of all discrimination complaints filed against the Health Plan and/or the Health Plan's employees, against the Health Plan's Providers, the Provider's employees, and /or the Provider's subcontractors in which discrimination is alleged as it relates to the provision of and/or access to IDHW Covered Services provided by the Health Plan. The report shall include, at a minimum: The identity of the complainant, the complainant's relationship to the Health Plan, who the complaint is filed against, circumstances of the complaint, type of covered service related to the complaint, date complaint was filed, the Health Plan's resolution, date of resolution, and the name of the Health Plan staff person responsible for adjudication of the complaint. For each complaint reported as resolved, the Health Plan shall submit a copy of the complainant's letter of resolution. Where a discrimination complaint is substantiated, the report shall describe the measures taken by the Health Plan to prevent similar discriminatory actions in the future.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Quarterly, thirty (30) days after the end of each quarter

Report Description: Specialized Service Report -- **FQHC, Rural Health Center, and Indian Health Clinic Report** – The report shall include encounter data records documenting Health Plan's reimbursement to FQHCs, Rural Health Centers, and Indian Health Clinics. The report shall include the following data for each claim: (a) Claim number; (b) Total claim lines; (c) Date of service; (d) Claim paid amount; (e) Third party payment; (f) Total claim payment; (g) Facility name; and (h)NPI. The report shall also include a narrative describing how the Health Plan accomplishes reconciliation between the Medicare and Medicaid encounter rates for each FQHC, RHC and IHC.

Report Format: Excel

Reporting Phase: Ongoing

Report Due: Annually

LIV. Transition Plan

A. The Health Plan shall provide and maintain a Transition Plan that complies with the requirements in this contract. The objective of the Transition Plan is to minimize the disruption of services provided to Enrollees and to provide for an orderly and controlled transition of the Health Plan's responsibilities to a successor at the conclusion of the contract period or for any other reason the Health Plan cannot complete the responsibilities of the contract. The Health Plan shall submit their Transition Plan within ninety (90) calendar days of the contract effective date and an updated Transition Plan to IDHW within one hundred eighty (180) calendar days prior to the conclusion of the contract.

B. IDHW will:

1. Pay the Capitated Payment through the end of the calendar month if termination occurs mid-month.

2. Withhold twenty percent (20%) of the Health Plan's last capitated payment until the Health Plan has complied with all contractual obligations. IDHW's determination of completion of the Health Plan's contractual obligations will be no sooner than six (6) months from the date of termination. Failure to complete said contractual obligations within a reasonable time period shall result in a forfeiture of the twenty percent (20%) withhold.

C. The Health Plan shall:

1. Cooperate with the IDHW during the planning and transition of contract responsibilities from the Health Plan to a replacement health plan or the IDHW including, but not limited to sharing and transferring Enrollee information and records, as required by the IDHW.

2. Retain responsibility for:

a) Payment for Medicaid inpatient covered services for Enrollees hospitalized on or before the day of contract termination or expiration through

the date of discharge, including the diagnosis related group (DRG) payment and any outlier payments.

b) Payment for services rendered through the day of termination or expiration of the contract, for which payment is denied by the Health Plan and subsequently approved upon appeal by the Provider.

c) Resolving Enrollee Grievances and Appeals with respect to claims with dates of service prior to the day of contract expiration.

d) Financial responsibility for Enrollee appeals of adverse decisions rendered by the Health Plan.

e) Retention of records that fully disclose the extent of services provided to Enrollees under the contract for a period of six (6) years in accordance with 42 CFR § 455, 45 CFR § 164.530(j)(2) and IDAPA 16.03.09.205, or for the duration of contested case proceedings, whichever is longer.

f) Capitation reconciliation.

3. Ensure Enrollee services are not interrupted or delayed during the remainder of the contract and the contract transition planning by all parties shall be cognizant of this obligation. The Health Plan shall:

a) Make provisions for continuing all management and administrative services and the provision of services to Enrollees until the transition is completed and all other requirements of this contract are satisfied.

b) Ensure continuation of services for the period in which a capitation payment has been made, including inpatient admissions until discharge.

c) Provide orderly transfer of Enrollee care and Enrollee records to those Providers who will assume care for the Enrollee.

d) Provide orderly and reasonable transfer of Enrollee care-in-progress, and Enrollee records whether or not those Enrollees are hospitalized.

e) Provide timely submission of information, reports, and records, including submission and corrections to encounter and performance data and verification of over and underpayments required during the term of the contract.

f) Provide timely payment of valid claims for services to Enrollees for dates of service included in the contract term.

g) Ensure that if the Health Plan continues to provide services to one (1) or more Enrollees after the date of termination, IDHW pays only for services, subject to IDHW rules on a fee-for-service basis if the patient is Medicaid eligible and not covered under any other IDHW contractor. If the Health Plan chooses to provide services to a former Enrollee who is no longer eligible, IDHW shall have no responsibility to pay for such services.

h) Retain responsibility for any and all claims from subcontractors or Providers, including emergency service Providers, for services provided prior to the termination date.

i) Notify Providers, subcontractors, and Enrollees of the contract termination, as directed by the IDHW, including transfer of Provider network participation to the IDHW or their designee. The IDHW will work collaboratively on communications regarding the transition/termination of the contract.

D. The Transition Plan shall include, but is not limited to:

1. A realistic schedule and timeline to hand-off responsibilities from the Health Plan either back to the IDHW or to another Health Plan designated by the State.
2. The staff that shall be utilized during the hand-off of duties and their responsibilities such that there shall be clear lines of responsibility between the current Health Plan, the new Health Plan, and the IDHW.
3. The actions that shall be taken by the current Health Plan to cooperate with the new Health Plan and the IDHW to ensure a smooth and timely transition.
4. A plan on how to best inform and keep the current Health Plan's employees, Providers, and subcontractors informed during the transition process.
5. A matrix listing each transition task, the functional unit and the person, agency, or Health Plan responsible for the task, the start and deadline dates to complete the planned tasks, and a place to record completion of the tasks.
6. All information necessary for reimbursement of outstanding claims.

LV. Cost/Billing Procedure

Cost:

The contract shall be a FIRM FIXED FEE, INDEFINITE QUANTITY contract for services specified in the Scope of Work and Technical Requirements.

The number of "Per Eligible Member Per Month (PMPM)" listed below is the Department's current estimate and may vary from the actual number of eligible Enrollees that may be served. Estimated quantity is for evaluation purposes and is not to be considered a guarantee of actual number of Enrollees to be served under the contract.

For payment purposes, the most current eligible Enrollee count is based on the number of eligible Enrollees as indicated on the eligibility file as of the fifth (5th) calendar day of the month multiplied by the Total PMPM cost in Cost Matrix 2 below (Section LVIV. Health Plan-Specific Provisions), column F2, cell S2. The capitated payment from IDHW is intended to be adequate to support Enrollee access to and utilization of Covered Services. IDHW will monitor Enrollee access to care and the financial viability of the Health Plan. The Health Plan shall accept the PMPM rate paid by IDHW as payment in full for all Covered and Supplemental Services provided pursuant to this contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. Any and all costs incurred by the Health Plan in excess of the PMPM rate payment shall be borne in full by the Health Plan.

The Health Plan shall provide services to all eligible Enrollees identified in the eligibility file transmitted from IDHW.

Three (3) months prior to the first contract month the Enrollee status will be determined for the purpose of blending the proposed capitation rates. The total PMPM payment is comprised of two (2) components; the Medical capitation and the blended Long-Term Services and Supports (LTSS). Once the eligible Enrollee count by enrollment status is determined for the contract, the blended LTSS and Medical rate will remain in effect through the contract period.

Rate Setting In accordance with 42 CFR 438 rates may be adjusted to maintain actuarial soundness on an annual basis.

The PMPM cost, which includes administrative costs and quality improvement costs, is effective through the end of the first contract period. The IDHW will conduct actuarial analyses for each subsequent contract period. The IDHW retains the option to amend the PMPM Cost based on actuarial findings. Additional information regarding the Medical Loss Ratio and risk mitigation may be found in the Scope of Work Medical Loss Ratio Settlements, Rate Review, Payments in Future Years, and Mid-Year Rate Adjustments Section.

Administrative Costs: The rate provides a fully-burdened rate for the Administrative Costs for Enrollees. Administrative Costs are capped and may not exceed fifteen percent (15%) of the total PMPM costs.

Quality Improvement Costs: The rate includes an allowance for quality improvement costs.

PMPM Costs: The rate includes two (2) PMPM costs; one (1) for the Medical (Cost Matrix 2) and one (1) for LTSS (Cost Matrix 1).

Cost Matrix 1 “Contract Period 1 LTSS Rate Blending” :

The LTSS rate blending will be based upon all Health Plan’s Medicare Medicaid Coordinated Plan Dual Eligibles and their eligibility status three (3) months prior to the contract period.

The cost per unit for each item is entered in the column labeled “(C1) PMPM Claim Cost” and “(D1) PMPM Admin Cost.” Multiply the “(B1) Unit – Per Eligible Member Per Month (PMPM)” by the “(E1) Total PMPM Cost” and enter the product in the column “(F1) Units after ILOC Transition Percentage.” Add the product of “(E1) Total PMPM Cost” and “(F1) Units” and divide by the Monthly Total of “(B1) Unit – Per Eligible Member Per Month (PMPM)” in “(S1) Monthly Total LTSS PMPM Cost SUM (E1*F1)/3000.”

Cost Matrix 2 “Total Capitation Rate Blending”:

The cost per unit is entered in the column labeled “(C2) PMPM Claim Cost” and “(D2) PMPM Admin Cost.” Multiply the “(E2) LTSS PMPM Cost (Matrix 1 – S1)” by the “(F2) Total PMPM Cost” and enter the product in the column “Total PMPM Cost (C2+D2+E2).” Add the product of “(B2) Unit - Per Eligible Member Per Month (PMPM)” and “(F2) Total PMPM Cost” and divide by the Monthly Total of “(B1) Unit – Per Eligible Member Per Month (PMPM)” in “(S2) Monthly Total PMPM Cost SUM (B2*F2)/3000” and enter into the Monthly cell “PMPM Cost.”

Billing Procedure:

The Health Plan shall submit deliverables in accordance with established timelines and encounter data to the IDHW's MMIS contractor. Per 42 CFR § 438.60 no supplemental payments shall be made to any network Provider outside of the contract for services provided.

The IDHW will pay the Health Plan for services on a monthly basis in accordance with requirements for managed care organizations specified in 42 CFR § 438. IDHW will make a capitation payment based on this number on or before the tenth (10th) business day of the month. The capitation payment will include payment or adjustments for Enrollees whose plan eligibility status has been determined retroactively by the IDHW. In the case of PMPM overpayments to the Health Plan, the IDHW will provide a separate overpayment bill.

The IDHW will provide, and the Health Plan shall accept an 820 Payroll Deducted and Other Group Premium Payment for Insurance Products EDI transaction. The Health Plan shall create an error report from the 820 Payment Order/Remittance Advice EDI transmission in order to reconcile any discrepancies identified. The Health Plan shall review the error report against its own records and transmit an 820 Payment Order/Remittance Advice EDI transmission with corrected Enrollee enrollment and disenrollment information. The Health Plan shall enroll and disenroll Enrollees in the current month or future months when the Health Plan submits the 820 Payment Order/Remittance Advice EDI transmission to IDHW. No retroactive enrollment or disenrollment will be accepted by IDHW unless IDHW agrees to an exception to retroactive enrollment or disenrollment on a case by case basis. The Health Plan shall review the report against its own records and report any inconsistencies or errors to the IDHW for review, confirmation, and reconciliation.

Inquiries, reports of payment inconsistencies or errors, and deliverables shall be submitted to:

Division of Medicaid

Bureau of Long Term Care

3232 Elder Street

Boise, ID 83705

Phone: (208) 732-1482

Fax: (208) 736-2116

E-mail: Mandi.Hanifen@dhw.idaho.gov

LVI. Attachments

A. This Agreement consists of this document and the following attachments:

Attachment 1: Enrollee Rights

Attachment 2: Enrollee Handbook

Attachment 3: Network Provider Subcontracts

Attachment 4: Plan Benefit Package (PBP)

Attachment 5: Contract Definitions

Attachment 6: Transition Requirements at Enrollment

Attachment 7: Access Standards

Attachment 8: Wellness Assessment

Attachment 9: Individualized Care Plan

Attachment 10: Information Systems

Attachment 11: Provider Services Helpline, Call Center/Helpdesk, and IVR Requirements

Attachment 1 - Enrollee Rights

The Health Plan shall perform all of the following requirements under the contract with the Idaho Department of Health and Welfare. All tasks in Attachment 1 – Enrollee Rights are part of the Scope of Work and are mandatory.

I. Enrollee Rights

A. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the right to receive information, including but not limited to: all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.

B. The Health Plan shall comply with any applicable federal and State statutes and regulations that pertain to Enrollee rights, and ensure that its staff and affiliated providers take those rights into account when furnishing services to Enrollees. 42 CFR § 438.100(a)(2)

C. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the freedom to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Health Plan, its Providers, and the State treat the Enrollee. 42 CFR § 438.100(c)

D. The Health Plan shall adopt methods and procedures that require each Enrollee to be treated with respect and with due consideration for his or her dignity and privacy. 42 CFR § 438.100(b) (2) (ii)

E. The Health Plan shall allow each Enrollee to choose his or her health professional to the extent possible and appropriate. 42 CFR § 438.3(l)

F. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand. 42 CFR § 438.100(b) (2) (iii)

G. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the right to participate in decisions regarding his or her health care, including the right to refuse treatment. 42 CFR § 438.100(b)(2)(iv)

H. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. 42 CFR § 438.100(b)(2)(v)

I. The Health Plan shall adopt methods and procedures that guarantee each Enrollee the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR § 164.524 & .526 and 42 CFR § 438.100(b)(2)(vi).

J. The Health Plan shall comply with applicable federal and State statutes and regulations (such as, Title VI of the Civil Rights Act of 1964; The Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act) and other laws regarding privacy and confidentiality. 42 CFR § 438.100(d)

K. The Health Plan shall adopt methods and procedures that meet the requirements of 42 CFR § 422.128 and 42 CFR § 489 Subpart I concerning advance directives.

Attachment 2 - Enrollee Handbook

The Health Plan shall perform all of the following requirements under the contract with the Idaho Department of Health and Welfare. All tasks in Attachment 2 Enrollee Handbook are part of the Scope of Work and are mandatory.

I. Enrollee Handbook

A. The Health Plan shall develop, print, and distribute an Enrollee Handbook and update it at least annually.

B. Upon notice to IDHW of material changes to the Enrollee Handbook, the Health Plan shall make appropriate revisions and immediately distribute the revised Enrollee Handbook to Enrollees and Providers.

C. The Health Plan shall distribute hard copies of the Enrollee Handbook to each Enrollee within thirty (30) calendar days of receipt of the request for enrollment to the Health Plan's plan, or prior to the Enrollee's enrollment effective date as described in Section XXI Enrollment, as handbooks are updated, whenever there are material revisions, and at least annually thereafter.

D. The Health Plan shall distribute the Enrollee Handbook to all in-network Providers upon initial credentialing, annually thereafter, as handbooks are updated, and whenever there are material revisions. For purposes of providing Enrollee Handbooks to Providers, it is acceptable to provide Enrollee Handbooks in electronic format, including, but not limited to, CD or access via a web link.

E. The Enrollee Handbook shall include but is not limited to:

1. The Health Plan's contact information including address, telephone number, Call Center/ Help Desk telephone numbers, and website;
2. The Health Plan's business hours and days;
3. A description of the terms and nature of services offered by the Health Plan;
4. All information required under 42 CFR § 438.10(f)(6) including, but not limited to:
   a) Any restrictions on the Enrollee's freedom of choice among in-network Providers,
   b) The extent to which Enrollees may obtain benefits, including family planning services, from out-of-network Providers;
   c) The amount, duration, and scope of services available under the contract in sufficient detail to ensure that Enrollees are informed of the services to which they are entitled; and
   d) The procedures for obtaining benefits, including authorization requirements;
5. Instructions on accessing carved-out services that are available under Medicaid FFS;
6. Grievance, appeal, and fair hearing procedures as required at 42 CFR § 438.10(g)(1), including the following:
   a) The right to file grievances and appeals;
   b) The requirements and timeframes for filing a grievance or appeal;
   c) The availability of assistance in the filing process;

d) The toll-free numbers that the Enrollee can use to file a grievance or appeal by phone;

e) The fact that, if requested by the Enrollee and under certain circumstances:

(1) Benefits will continue if the Enrollee files an appeal or requests a State fair hearing within the specified timeframes; and

(2) The Enrollee may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the Enrollee.

f) The right to a State hearing:

(1) The method for obtaining a hearing; and

(2) The rules that govern representation at the hearing.

7. The extent to which, and how, after-hours and emergency services are provided, as well as other information required under 42 CFR § 438.10(f)(6)(viii) related to emergency services; including

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

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

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

d) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization care services covered under the Health Plan.

e) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or setting for emergency care.

8. The post-stabilization care services rules set forth in 42 CFR § 422.113(c);

9. Any applicable policies on referrals for specialty care and other benefits not furnished by the Enrollee's PCP;

10. All cost-sharing information, including contact information where the Enrollee can ask questions regarding their cost-sharing obligations;

11. Information about the availability of non-emergency transportation and how to access services;

12. Enrollee rights and protections, as enumerated in 42 CFR § 438.100 and in accordance with Attachment 1 Enrollee Rights;

13. The standard approved Discrimination Complaint Form;

14. The responsibilities of Enrollees;

15. Special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the Health Plan's network;

16. Procedures for obtaining out-of-network services, including how to contact IDHW for information on how and where to obtain counseling or referral services not covered by the Health Plan due to moral or religious objections;

17. Standards and expectations for receiving preventive health services;

18. Procedures for changing Health Plans and circumstances under which this is possible;

19. Procedures for making complaints and recommending changes in policies and services;
20. Information about advance directives; as required by 42 CFR § 422.128, including the following:
    a) A description of State law concerning advanced directives and Enrollee rights under State law.
    b) The Health Plan's policies respecting the implementation of Enrollee rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
    c) Notification to Enrollees that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.
    d) Modification to written material after applicable changes in State law within 90 days after the effective date of the change.
21. Information for Enrollees regarding self-direction of services;
22. Information on Alternative Formats of communication for visually and hearing-impaired and non-English speaking Enrollees and how Enrollees can access Alternative Formats;
23. Information on how Enrollees can access IDAPA 16.05.03, Rules Governing Contested Case Proceedings and Declaratory Rulings either online or from an IDHW office. Rules are available at http://adminrules.idaho.gov/rules/current/16/0503.pdf.
24. Information regarding the appeals rights made available by IDHW to providers to challenge the failure of the Health Plan to cover a service.

Attachment 3 - Network Provider Subcontracts

All Provider subcontracts shall include, but not be limited to, the following provisions:

1. The name and address of the subcontractor.
2. The method and amount of compensation, reimbursement, payment, or other considerations provided to the Provider.
3. Identification of the population to be served by the Provider.
4. The methods by which the amount, duration, and scope of Covered Services are determined.
5. The term of the Provider's subcontract, including beginning and ending dates, and procedures for extension, termination, and renegotiation.
6. Specific Provider subcontract duties relating to coordination of benefits, cost sharing (if applicable), and determination of third-party liability.
7. Identification of third-party liability coverage and requirements for seeking third-party liability payments before submitting claims and/or encounters to the Health Plan, when applicable.
8. Compliance with the requirements in the Health Plan QM/QI and UM plans and QM/QI program.
9. Uniform terms and conditions of the contract.
10. Assumption of full responsibility for all tax obligations, worker's compensation insurance, and all other applicable insurance coverage obligations required in this contract, for itself and its employees, and that the IDHW shall have no responsibility or liability for any taxes or insurance coverage.
11. Incorporation by reference of the Health Plan's Provider Manual and language that the Provider subcontract complies with all requirements stated in this contract.
12. Compliance with encounter reporting and claims submission requirements in accordance with the Health Plan's Provider Manual, including payment withhold provisions and penalties for non-reporting, untimely reporting, or inaccurate reporting.
13. The right of a Provider to appeal a claims dispute in accordance with the Health Plan's Provider Manual.
14. Assistance to Enrollees to understand their right to file grievances and appeals in accordance with the Health Plan's Provider Manual shall be provided by the Provider.
15. Compliance by the subcontract with audits, inspections, and reviews in accordance with the Health Plan's Provider Manual, including any reviews the Health Plan or the IDHW may conduct.
16. Cooperation of the Provider with the Health Plan, other Providers, and/or State employees in scheduling and coordinating its services with other related service Providers that deliver services to Enrollees.
17. Facilitation by the Provider of another Provider's reasonable opportunity to deliver services, and the prohibition of any commission or condoning of any act or omission by the Provider that interferes with, delays, or hinders service delivery by another Provider or by State employees.
18. When applicable, submission of the National Outcome Measures to the IDHW, including access to services, engagement in services, independent and stable housing, employment, and employment training rates.

19. A requirement that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
20. The subcontractor acknowledges that it is aware of the False Claims Act (sections 3729 through 3733 of title 31, United States Code). In addition, any Provider that either receives or makes annual Medicaid payments of at least five million dollars ($5,000,000) acknowledges that they are required to comply with Title 42, United States Code, Section 1396a(a), paragraph (68) as amended by the Deficit Reduction Act of 2005. The Provider specifically acknowledges its responsibility regarding employee education about the False Claims Act and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.
21. To document each item or service for which reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of ID Code § 56-209(h)(3), the applicable rules and this agreement. Such records shall be maintained for at least five (5) years after the date of services or as required by IDAPA. Upon reasonable request, the IDHW, the U.S. Department of Health and Human Services or their agencies shall be given immediate access to, and permitted review and copy any and all records relied on by the Provider in support of services billed. The term "immediate access" shall mean access to the records at the time the written request is presented to the subcontractor.
22. To certify by the signature of the subcontractor or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and Medically Necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Health Plan rules, the IDHW rules, and this agreement. The subcontractor shall be solely responsible for the accuracy of claims submitted, and shall immediately repay the Health Plan for any items or services the Health Plan or the subcontractor determines were not properly provided, documented, or claimed. The subcontractor must assure that they are not submitting a duplicate claim under another program or Provider type.
23. The subcontractor acknowledges that the IDHW is not responsible for any payments to the subcontractor for Covered Services provided to Enrollees under this contract.
24. Subcontractors agree to accept the Health Plan's payment or appropriate denial (or, if applicable, payment by the Health Plan that is supplementary to the Enrollee's third-party payer) for any item or service as payment in full and agrees to make no additional charge to the Enrollee except that specifically allowed by IDHW. The subcontractor further agrees: that if required, it will submit requests for prior authorization before the time or service is provided. The subcontractor agrees not to bill the Enrollee for any services rendered unless specifically permitted to do so under cost-sharing rules and in the Provider subcontract. The subcontractor agrees not to bill the Health Plan or the Enrollee if a third party payment is made to the subcontractor unless the third party payment is less than the amount of the Health Plan payment plus any applicable Enrollee share of cost payment. The subcontractor shall not refuse to furnish services on account of a third party's potential liability for the services (42 CFR § 447.20).

25. The subcontractor acknowledges that, as a condition of receiving payment for Medicaid services, that the subcontractor is subject to IDAPA 16.05.07, “The Investigation and Enforcement of Fraud, Abuse, and Misconduct.”
26. To comply with the advance directives requirement of 42 CFR § 489, Subpart I, and 42 CFR § 417.436(d), when applicable.
27. To protect the confidentiality of identifying information that is collected, used or maintained about an Enrollee. Confidential information shall only be released with appropriate written authorization of the Enrollee, according to IDAPA 16.05.01, “Use and Disclosure of Department Records,” and 42 CFR § 431.300.
28. In no way shall any official, employee, or agent of the State of Idaho be in any way personally liable or responsible for any term of this agreement, whether expressed or implied, not for any statement, representation or warranty made in connection with this agreement.
29. No payment shall be made by the Health Plan to a subcontractor for a Provider Preventable Condition as defined in 42 CFR § 447.26(b) under the contract.
30. 29.30. The subcontractor agrees to comply, as a condition of payment under the contract, with reporting requirements on Provider Preventable Conditions in accordance with 42 CFR § 447.26(d) and as specified by the Health Plan and/or IDHW.
31. The subcontractor agrees to comply, as a condition of payment under the contract, with reporting requirements on Provider Preventable Conditions in accordance with 42 CFR § 447.26(d) and as specified by the Health Plan and/or IDHW.

Attachment 4 - Plan Benefit Package (PBP)

*Please note that all Medicaid services listed herein are covered only to extent that such services exceed Medicare service limitations for the same service, as Medicare is the primary payer for overlapping services. *

Service Name and IDAPA Reference	Service Definition	Benefit Plan Where Service is Offered	May Health Plan Require Authorization?	Limitations (if applicable)	Cost Sharing Permitted?

Inpatient Hospital Services IDAPA 16.03.09.400-406	Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist.	Basic and Enhanced Plans	Procedures generally accepted by the medical community and which are medically necessary may not require prior approval	No limitation is placed on the number of inpatient hospital days. Inpatient hospital services do not include those services provided in an institution for mental diseases. Organ transplant procedures may include organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers. The treatment of complications, consequences or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department or its authorized agent is excluded from Medicaid payment. Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician. Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from Medicaid payment. Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment. Procedures, counseling, and testing for the	No

Inpatient Psychiatric Services IDAPA 16.03.09.702-706 and 16.03.10.100-102	In addition to Psychiatric Services covered under Inpatient Hospital Services, the Enhanced Alternative Benefit Package includes Services for Certain Individuals in Institutions for Mental Diseases permitted under sections 1905(a)(14) of the Social Security Act. This includes services in institutions for mental disease for individuals age sixty-five (65) and over and individuals who are twenty-one (21) years of age.	Basic and Enhanced	Only for elective admissions.	Medicaid does not reimburse institutions for mental disease for individuals ages twenty-two to sixty-four (22-64).	No
Other Practitioner Services IDAPA 16.03.09.540-544 IDAPA 16.03.09.781-785	These services include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.	Basic and Enhanced Plans	Yes (except for urgent and emergency services)	Podiatrist Services are limited to treatment based on chronic care criteria and for treatment of acute foot conditions that, if left untreated could cause an adverse outcome to the Enrollee's health. Optometrist services are limited to providing eye examination and eyeglasses covered under this State plan unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.	No
Prevention Services: Prevention and Health Assistance	PHA benefits may be available to Enrollees for tobacco cessation and weight reduction/management in accordance with applicable IDHW rules. These goods and services may include nicotine patches or gum, weight-loss programs, dietary supplements, and other health related benefits.	Basic and Enhanced Plans	Yes	PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted health condition. These activities include discussing the condition with their primary	No

Benefits IDADPA 16.03.09.620-626				care provider, participating in an applicable support group, and completing basic educational material related to the condition.	
Prevention Services: Nutrition Services IDAPA 16.03.09.630-635	Nutritional services include intensive nutritional education, counseling, and monitoring. (IDAPA) The Enhanced Alternative Benefit Package includes intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by IDHW prior to the delivery of additional visits.	Basic and Enhanced Plans	Yes	Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the limitations in the definition when provided as PHA benefits.	No
Prescribed Drugs IDAPA 16.03.09.662	The Enhanced Alternative Benefit Package includes **Prescribed Drugs** permitted under sections 1905(a)(12), 2110(6) and 2110(a)(7) of the Social Security Act. These services include drugs prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins. Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products	Basic and Enhanced Plans	The following drugs require prior authorization under the Idaho Medicaid program: • Amphetamines and related CNS	**Note: Only the Medicaid prescribed drugs not already covered by Medicare Part D are required by Medicaid.** **Limitations.** The following service limitations apply to the Enhanced Alternative Benefit Package covered under the State Plan. Prior authorization will be required for certain drugs and classes of drugs. Prior Authorization criteria is developed by the Department's clinical pharmacists with input from the Medical	No

	requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by IDHW policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records including evidence of such medical necessity. Those records will be made available to IDHW upon request. The criteria used to determine medical necessity is stated in applicable IDHW rules. **Medicare Excluded Drug Products.** Effective January 1, 2006, IDHW will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B. IDHW provides coverage for the following Medicare excluded or otherwise restricted drugs or classes of drugs or their medical uses to all recipients of Medical Assistance under this State plan, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D. Lipase inhibitors subject to Prior Authorization. Prescription Cough & Cold symptomatic relief.		stimulants; • Growth hormones; • Retinoids; • Brand name drugs when acceptable generic form is available; • Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department; • Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines; • Medications	Director, the Pharmacy and Therapeutics Committee, and the Drug Utilization Review Board. The criteria used to place drugs on prior authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug, and quality evidence provided by established drug compendia, and the Drug Effectiveness Review Program. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within twenty-four (24) hours of the request. Pharmacies are authorized to dispense a seventy-two (72) hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in Section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The Enhanced Alternative Benefit Package has a limitation that no more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. To provide enhanced control over this limitation, the Point of Sale (POS) system has added an early refill edit to identify medication refills provided before at least seventy five percent (75%) of the	

	Therapeutic Vitamins which may include: • Injectable Vitamin B12; • Vitamin K and analogues; • Legend folic acid; • Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and • Legend Vitamin D and analogues. Nonlegend Products which may include: • Insulin; • Oral iron salts; • Permethrin; and • OTC products as authorized by applicable IDHW rules. Barbiturates. Benzodiazepines. **Additional Covered Drug Products.** Additional drug products will be covered as follows: • Therapeutic Vitamins; • Injectable Vitamin B12 (cyanocobalamin and analogues); • Vitamin K and analogues; • Pediatric vitamin-fluoride preparations; • Legend prenatal vitamins for pregnant or lactating women;		prescribed outside of the FDA approved indications; • Lipase inhibitors; and • FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been determined by the Department to be medically necessary.	estimated days' supply has been utilized. This edit can be overridden by the pharmacy if a change in dosage is ordered. The edit is designed to prevent waste and abuse by preventing unnecessary refills, and identify clients who may be accessing multiple physicians and pharmacies and stockpiling medications. The following medications are the only exceptions to the thirty-four (34) day supply limitation. Up to one hundred (100) unit doses or a one hundred (100) day supply, whichever is less, of the following medications may be purchased: • Cardiac glycosides; • Thyroid replacement hormones; • Prenatal vitamins; • Nitroglycerin sublingual and dermal patch products; • Fluoride and vitamin fluoride combination products; and • Nonlegend oral iron salts. Oral contraceptive products may be purchased in a quantity sufficient for one (I), two (2), or three (3) cycles. Excluded Drug Products. The following categories and specific products are excluded:	

	• Legend folic acid; • Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and • Legend Vitamin D and analogues. Prescriptions for non-legend products will be covered as follows: • Insulin; • Tobacco cessation products; • Oral iron salts; and • Permethrin, and • Federal legend medications that change to non-legend status, as well as their therapeutic equivalents, based on Director approval which is determined by appropriate criteria including safety, effectiveness, clinical outcomes, and the recommendation of the P&T committee.			• Legend drugs for which Federal Financial Participation (FFP) is not available • Nonprescription items (without the Federal Legend), except permethrin and oral iron salts. • Ovulation stimulants and fertility enhancing drugs. • Medications used for cosmetic purposes. • Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid. • Diet supplements and weight loss products are excluded unless provided as PHA benefits or when provided to pregnant women. • Nicotine cessation products are excluded unless provided as PHA benefits, or when provided for pregnant women.	
Family Planning Services IDAPA 16.03.09.681-683	The Enhanced Alternative Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives. Family planning services and supplies for individuals of child-	Basic and Enhanced Plans	No	Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of twenty-one (21) that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must	No

	bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Enhanced Alternative Benefit Package covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.			voluntarily sign the informed consent form at least thirty (30) days, but not more than one hundred eighty (180) days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.	
Community-Based Outpatient Behavioral Health Services IDAPA 16.03.09.707-711	**Community-Based Outpatient Behavioral Health Services.** Behavioral health services are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include: **Screening, Evaluation, and Diagnostic Assessments (includes occupational therapy assessments).** Assessment and evaluation define or delineate the individual's mental health/substance use disorder diagnoses and related service needs. Assessment and evaluation services are used to document the nature of the individual's behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance abuse and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate);	Basic and Enhanced	Yes	All Community-Based Outpatient Behavioral Health Services are subject to the limitation of practice imposed by state law, federal regulations and according to applicable Department rules, the Idaho Medicaid Provider Agreement Medicare-Medicaid Coordinated Plan as awarded or amended and approved by the Department or its authorized agent based upon medical necessity.	No

	and 2) a written report on the evaluation results to impart the evaluator's professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives. **Treatment Planning.** The treatment plan refers to a written document that outlines the prescribed treatment for the individual using multidisciplinary assessment and evaluation documentation completed and gathered. The treatment plan is updated to reflect the progression of therapy. **Psychotherapy (Group and Family)** • **Group.** Group psychotherapy consists of group therapeutic interventions provided to Medicaid eligible individuals to address alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three (3) or more, but fewer than ten (10) individuals. • **Family Psychotherapy.** Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few				

	of the issues that may be addressed. The State Plan service allows for any combination of family members, whether just adults or adults with children/adolescents. • **Partial Care Treatment.** A distinct and organized intensive ambulatory treatment service offering less than twenty-four (24) hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization. • **Behavioral Health Nursing.** Professional services directed at the reduction of disability or restoration of functioning related to a Member's mental health problems and the care and treatment of persons with behavioral health disorders. • **Occupational Therapy.** For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness. • **Drug Screening.** Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings, and blood tests. • **Community-Based Rehabilitation and Substance Use Disorder Treatment Services.** These services consist of community-based evidence-based practices that are restorative interventions or				

	interventions that reduce disability and that are provided to Members with serious, disabling mental illness, emotional disturbance or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse. ○ Interventions for psychiatric symptomatology will use an active, assertive outreach approach and including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports. ○ Interventions for substance abuse disorders will include substance use disorder treatment planning, psycho-education and supportive counseling which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access				

	needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the member.				
Behavioral Health Case Management Services IDAPA 16.03.09.709	Behavioral Health case management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance: Assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include: **Taking client history:** Identifying the individual's needs and completing related documentation; Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual. **Development (and periodic revision) of a specific care plan that:** Is based on the information collected through the assessment; Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual; Includes activities such as ensuring the active participation	Basic and Enhanced Plans	Yes	Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F). Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care	No

	of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and Identifies a course of action to respond to the assessed needs of the eligible individual. **Referral and related activities:** To help an eligible individual obtain needed services including activities that help link an individual with: Medical, social, educational providers; or Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual. **Monitoring and follow-up activities:** Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities and contract may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met: services are being furnished in accordance with the individual's care plan; services in the care plan are adequate; and if there are changes in the needs or status of the individual's necessary adjustments are made to the care plan and service arrangements with the providers. Case Management may include: Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible			subsidies; making placement arrangements. (42 CFR 441.18(c)) FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))	

	individual to access services.				
Medical Equipment, Supplies and Devices; Prosthetic Devices IDAPA 16.03.09.771-773	The Enhanced Alternative Benefit Package includes **Prosthetic Devices P**ermitted under sections 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics. IDHW will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.	Basic and Enhanced Plans	Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent.	Limit of one (1) refitting, repair or additional parts in a calendar year.	No
Vision Services IDAPA 16.03.09.781-785	The Enhanced Alternative Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(5), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.	Basic and Enhanced Plans	Yes	The Department will pay for vision exams if: 1) The Services are based on chronic care criteria and are necessary to monitor a chronic condition that could harm the person's vision. 2) The Enrollee has an acute condition that, if left untreated, may cause permanent or chronic damage to the eye. The Department will pay for eyeglasses only when necessary to treat a medical condition or one (1) pair following cataract surgery.	No
Long-Term Care	The Enhanced Alternative Benefit Package includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of	Enhanced Plan	Nursing facility care services	Skilled nursing facility services must have prior authorization before payment is	Members in long-term care facilities

Services; Nursing Facility Services IDAPA 16.03.10.220-296	the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.		must have prior authorization before payment is made.	made. For individuals age twenty-one (21) and older, such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment. Nursing facility care services must have prior authorization before payment is made.	may be required to pay a patient liability for the cost of the long-term care services to the long-term care facilities in accordance with IDAPA 16.03.10.224 and 16.03.05.722-726.
Long-Term Care Services; Personal Care Services IDAPA 16.03.10.300-308	"Personal care services (PCS)" means a range of medically oriented care services related to a Enrollee's physical or functional requirements. These services are provided in the Enrollee's home or personal residence but do not include housekeeping or skilled nursing care.	Enhanced Plan	Yes	Services are limited to sixteen (16) hours per calendar week, per eligible Enrollee.	No
Hospice Care IDAPA 16.03.10.450-460.	The Health Plan must pay the hospice agency a per diem amount for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services, consistent with IDAPA 16.03.10.459.08 and applicable hospice rules in IDAPA 16.03.10.450-460. In this context, the term “room and board” includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident’s room, and supervision and assisting in the use of	Enhanced Plan	Yes	The Health Plan is not required to pay for hospice services outside of a certified nursing facility where hospice residents are receiving routine or continuous care services.	Yes

	durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in IDAPA 16.03.10.457 and 16.03.10.459. The room and board rate shall be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the Enrollee was a resident of that facility.				
Specific Pregnancy-Related Services IDAPA 16.03.09.890-895	When ordered by the Enrollee's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. **01. Individual and Family Social Services**. Limited to two (2) visits during the covered period. **02. Maternity Nursing Visit**. These services are only available to women unable to obtain a physician, NP, PA, or NM to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. **03. Nursing Services**. Limited to two (2) visits during the covered period. **04. Nutrition Services**. Nutritional services are described in Sections 630 through 632 of these rules. **05. Qualified Provider Risk Assessment and Plan of Care**. When prior authorized by IDHW, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.	Basic and Enhanced Plans	Yes	Limitations are built into service definition.	No

Adult Day Health IDAPA 16.03.10.320-330	Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the Enrollee in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the Enrollee. Adult day health services provided under this waiver will not include room and board payments.	A&D Waiver	Yes	On the A&D waiver, Enrollees residing in a home-based setting may only receive adult day health care services twelve (12) hours in any twenty-four (24) hour period. Enrollees residing in a certified family home may only receive adult day health care services if there is an assessed unmet socialization need that cannot be provided by the certified family home provider. Adult day health care services are not offered to Enrollees who reside in a Residential Assisted Living Facility.	Yes - Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Day Habilitation IDAPA 16.03.10.320-330	Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the Enrollee resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in an Enrollee's plan of care. Day habilitation services will focus on enabling the Enrollee to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.	A&D Waiver	Yes	Limited to thirty (30) hours a week.	Yes - Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

Homemaker Services IDAPA 16.03.10.320-330	Homemaker services consist of performing for the Enrollee, or assisting him with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks.	A&D Waiver	Yes	Hours are to be determined by the Uniform Assessment Instrument (UAI).	Yes - Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Residential Habilitation IDAPA 16.03.10.320-330	Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible Enrollees. These services and supports are designed to assist the Enrollees to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home	A&D Waiver	Yes		Yes - Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

	safety, first aid, and emergency procedures; iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the Enrollee to his community. Socialization training associated with participation in community activities includes assisting the Enrollee to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the Enrollee to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. vii. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on his or her own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered,				

	supervision, communication assistance, reporting changes in the waiver Enrollee's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence.				
Respite IDAPA 16.03.10.320-330	Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or Enrollee is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver Enrollee cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the Enrollee's residence, a Certified Family Home, a Developmental Disabilities Agency, a Residential Assisted Living Facility, or an Adult day health facility.	A&D Waiver	Yes	Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers.	Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Supported Employment IDAPA 16.03.10.320-330	Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. **a.** Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each	A&D Waiver	Yes	Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA).	Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

	individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. **b.** FFP cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver Enrollees to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver Enrollee's supported employment program.				
Attendant Care IDAPA 16.03.10.320-330	Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the Enrollee and accommodating the Enrollee's needs for long-term maintenance, supportive care, or activities of daily living. These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the Enrollee. Services are based on the Enrollee's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the Enrollee to perform a task.	A&D Waiver	Yes	Hours are to be determined by the UAI.	Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Adult Residential Care	Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include residential care or assisted living facilities and certified family homes. Payment is not made for the cost of room and	A&D Waiver	Yes	Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.	Yes- Deductions are subtracted from countable income after exclusions to

IDAPA 16.03.10.320-330	board, including the cost of building maintenance, upkeep and improvement. **a.** Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that include: i. Medication management; ii. Assistance with activities of daily living; iii. Meals, including special diets; iv. Housekeeping; v. Laundry; vi. Transportation; vii. Opportunities for socialization; viii. Recreation; and ix. Assistance with personal finances. x. Administrative oversight must be provided for all services provided or available in this setting. xi. A written individual service plan must be negotiated between the Enrollee or his legal representative, and a facility representative. **b.** Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Rules Governing Certified Family Homes," that include: i. Monitoring of medications management; ii. Assistance with activities of daily living;				determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

	iii. Meals, including special diets; iv. Housekeeping; v. Laundry; vi. Transportation; vii. Recreation; and viii. Assistance with personal finances. ix. Administrative oversight must be provided for all services provided or available in this setting. x. A written individual service plan must be negotiated between the Enrollee or his legal representative, and a facility representative.				
Chore Services IDAPA 16.03.10.320-330	Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: **a.** Intermittent assistance may include the following. i. Yard maintenance; ii. Minor home repair; iii. Heavy housework; iv. Sidewalk maintenance; and v. Trash removal to assist the Enrollee to remain in the home. **b.** Chore activities may include the following: i. Washing windows; ii. Moving heavy furniture;	A&D Waiver	Yes		Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

	iii. Shoveling snow to provide safe access inside and outside the home; iv. Chopping wood when wood is the Enrollee's primary source of heat; and v. Tacking down loose rugs and flooring. **c.** These services are only available when neither the Enrollee, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. **d.** In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the Enrollee.				
Companion Services IDAPA 16.03.10.320-330	Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the Enrollee, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the Enrollee. However, the primary responsibility is to provide companionship and be	A&D Waiver	Yes	Companion services are not authorized for Enrollees living in Certified Family Homes or Residential Assisted Living Facilities. Companion services do not include room and board.	Yes-Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.

	there in case they are needed.				
Consultation IDAPA 16.03.10.320-330	Consultation services are services to an Enrollee or family member. Services are provided by a Personal Assistance Agency to an Enrollee or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the Enrollee and the Enrollee's family. Services include consulting with the Enrollee and family to gain a better understanding of the special needs of the Enrollee and the role of the caregiver.	A&D Waiver	Yes		Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Environmental Accessibility Adaptations IDAPA 16.03.10.320-330	Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the Enrollee to function with greater independence in the home, or without which, the Enrollee would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: **a.** The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver Enrollee, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the Enrollee, such as carpeting, roof repair, or central air conditioning. **b.** Unless otherwise authorized by IDHW, permanent environmental modifications are limited to a home that is the Enrollee's principal residence, and is owned by the Enrollee or the Enrollee's non-paid family.	A&D Waiver	Yes	Unless otherwise authorized by IDHW, permanent environmental modifications are limited to a home that is the Enrollee's principal residence, and is owned by the Enrollee or the Enrollee's non-paid family.	No

	c. Portable or non-stationary modifications may be made when such modifications can follow the Enrollee to his next place of residence or be returned to IDHW.				
Home Delivered Meals IDAPA 16.03.10.320-330	Home delivered meals are meals that are delivered to the Enrollee's home to promote adequate Enrollee nutrition. One (1) to two (2) meals per day may be provided to an Enrollee who: **a.** Rents or owns a home; **b.** Is alone for significant parts of the day; **c.** Has no caregiver for extended periods of time; and **d.** Is unable to prepare a meal without assistance.	A&D Waiver	Yes	One (1) to two (2) meals per day may be provided to an Enrollee who: a. Rents or owns a home; b. Is alone for significant parts of the day; c. Has no caregiver for extended periods of time; and d. Is unable to prepare a meal without assistance.	Yes - Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Non-medical Transportation IDAPA 16.03.10.320-330	**Non-Medical Transportation**. Non-medical transportation enables a waiver Enrollee to gain access to waiver and other community services and resources. **a.** Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. **b.** Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized.	A&D Waiver	Yes	Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized.	No
Personal Emergency Response System	PERS is an electronic device that enables a waiver Enrollee to secure help in an emergency. The Enrollee may also wear a portable "help" button to allow for mobility. The system is connected to the Enrollee's phone and programmed to signal a response center once a "help" button is activated.	A&D Waiver	Yes	This service is limited to Enrollees who: a. Rent or own a home, or live with unpaid caregivers; b. Are alone for significant parts of the	Yes - Deductions are subtracted from countable income after exclusions to determine the base

IDAPA 16.03.10.320-330	The response center is staffed by trained professionals. This service is limited to Enrollees who: **a.** Rent or own a home, or live with unpaid caregivers; **b.** Are alone for significant parts of the day; **c.** Have no caregiver for extended periods of time; and **d.** Would otherwise require extensive, routine supervision.			day; c. Have no caregiver for extended periods of time; and d. Would otherwise require extensive, routine supervision.	amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Skilled Nursing IDAPA 16.03.10.320-330	Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit.	A&D Waiver	Yes	Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit.	Yes- Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18.
Specialized Medical Equipment and Supplies IDAPA 16.03.10.320-330	**a.** Specialized medical equipment and supplies include: i. Devices, controls, or appliances that enable an Enrollee to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. **b.** Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the	A&D Waiver	Yes	Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the Enrollee.	No

	Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the Enrollee.				

Attachment 5 - Contract Definitions

The following terms, if appearing capitalized in the contract, the Attachments and/or the Appendices will have the following meaning unless the context clearly indicates otherwise.

1. 1915(c) Consumer-Directed DD Waiver Services - Consumer-directed waiver services, as defined in IDAPA 16.03.13, accessed by Enrollees with developmental disabilities (DD) who meet intermediate care facility for persons with intellectual disabilities (ICF/ID) level of care (LOC) eligibility criteria.
2. 1915(c) Traditional DD Waiver Services - Traditional waiver services, as defined in IDAPA 16.03.10.703, accessed by Enrollees with DD who meet ICF/ID LOC eligibility criteria.
3. 1915(c) Home and Community-Based Services Waivers (HCBS Waivers) – A federally approved program that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to certain Medicaid beneficiaries.
4. 1915(i) services - DD agency services and community crisis supports accessed by Enrollees who meet DD eligibility criteria and offered through the State Plan Amendment option.
5. Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care or in physical harm, pain, or mental anguish to a medical assistance Enrollee. It also includes Enrollee practices that result in unnecessary cost to the Medicaid program, or Enrollee utilization practices which may endanger their personal health or safety.
6. Accessible PDF Materials - A document or application is considered accessible if meets certain technical criteria and can be used by people with disabilities.
7. Action – As defined by 42 CFR § 438.400 an action by the Health Plan that includes the following: (1) The denial or limited authorization of a requested service, including the type or level of service; or (2) The reduction, suspension, or termination of a previously authorized service; or (3) The denial, in whole or in part, of payment for a service; or (4) The failure to provide services in a timely manner, as defined by IDHW; (5) The failure of the Health Plan to act within the timeframes provided in 42 CFR § 438.408(b); or (6) For a rural area resident with only one Health Plan, the denial of an Enrollee's request to obtain services outside the network:
    a) from any other provider (in terms of raining, experience, and specialization) not available within the network;
    b) from a provider not part of the network who is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to the participating provider within 60 days;
    c) because the only plan or provider available does not provide the service because of moral or religious objections;

d) because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network; or

e) IDHW determines that other circumstances warrant out-of-network treatment.

8. Activities of Daily Living (ADLs) – The performance of basic self-care activities in meeting an Enrollee's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks.

9. Administration (Administrative) Costs – Includes, but is not limited to startup costs, operating and personnel expenses, such as salaries, profit; supplies; travel; quality improvement; recruiting, enrolling, and maintaining a provider network; hiring, training, and maintaining sufficient staff to implement, administer, and manage the requirements of this contract; verifying eligibility for Enrollees and providers; claims processing and prior authorization of services, when required; maintaining and reporting claims data; monitoring claims and reporting patterns of potential overutilization, fraud, and abuse to the IDHW; providing Customer Service for Enrollees and providers; paying providers; and participating in the IDHW's Appeal and Fair Hearing processes when required by the IDHW. For the purposes of the managed care model of service delivery, all aspects of case management and care management are also included as administrative costs.

10. Alternative Formats – The provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats include, but are not limited to Braille, large font (at least 16 point), computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays, qualified interpreters for the Deaf, and audio tape, videotape, and Enrollee information read aloud to an Enrollee by an Enrollee services representative.

11. Americans with Disabilities Act of 1990 (ADA) – The ADA prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. The ADA also establishes requirements for telecommunications relay services.

12. Appeal – A request by an Enrollee or an Enrollee's representative for formal review of an Action of a Health Plan. This includes an Enrollee's request for review of a Health Plan's coverage or payment determination.

13. Capitated Payment - Monthly payment to the Health Plan on behalf of each Enrollee for the provision of services under this contract. Payment is made if the Enrollee receives or does not receive services during the month.

14. Care Coordination - A case management activity which assists Enrollees in gaining and coordinating access to necessary care and services appropriate to the needs of the Enrollee. Care coordination includes plan assessment and periodic re-assessment; development of an Individualized Care Plan, referral activities, monitoring activities that ensure the Enrollee's Individualized Care Plan is implemented and adequately addresses the Enrollee's needs, and crisis assistance. In order to ensure there is no conflict of interest, Care Specialists may not

provide both care coordination and any other services to the same Enrollee. Care coordination activities must be performed at the primary care practice level.

15. Care Specialist shall mean an individual with a minimum of a two-year degree or a minimum of two years' experience in healthcare or a healthcare-related industry, if said individual is working under direct oversight of a registered nurse, licensed practical nurse, physician's assistant, or a licensed social worker, who is the designated point of contact and who coordinates care for Enrollees.

16. Care Management - A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care.

17. Centers for Medicare and Medicaid Services (CMS) – The federal agency under the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

18. Centralized Enrollee Record – Centralized and comprehensive documentation that contains information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions.

19. Claims Management – An electronic system for processing claims that has the ability to handle online submission of individual claims by providers as well as accept and process batches of claims submitted electronically with the exception of claims that require written documentation to justify payment.

20. Claim - A bill for services, a line item of service, or all services for one recipient within a bill.

21. Clean Claim - A claim that contains all required data elements needed to process the submission and has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

22. Cold-call Contacts - Unsolicited personal contact by the Health Plan with a Potential Enrollee for the purpose of marketing.

23. Community Well – If an Enrollee does not meet the definition of Institutional member or ILOC-HCBS (see definitions below) then they are "Community Well" and will be categorized by the age bands for the rate variation. (Actuarial definition for an Enrollee categorization of all Enrollees based on where claims are paid for the Enrollee in a given month and what type of claims are made.

24. Complaint – See "Grievance."

25. Comprehensive Health Insurance – Major medical coverage that at least includes physician and hospital services.

26. Wellness Assessment shall mean the tool the Health Plan uses to identify the specialized needs of its Enrollees. For purposes of this definition and this Contract, a Wellness Assessment may be performed either in person or via telephonic means, including telephone and 2-way video.

27. Co-Occurring Disorders (COD) – The presence of mental and addictive disorders. Enrollees said to have COD have one (1) or more addictive disorders as well as one (1) or more mental disorders.

28. Contract Management Team - A group of IDHW representatives responsible for overseeing the contract.

29. Contract Year – A twelve (12) month period commencing the contract effective date.

30. Co-payment – The amount an Enrollee is required to pay a provider for specified services.

31. Corrective Action Plan (CAP) - A plan designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency.

32. Covered Services – The set of services to be offered by the Health Plan and defined in the Plan Benefit Package.

33. CPT – Current Procedural Terminology ®, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

34. Credentialing - The Health Plan's process for verifying and monitoring providers' licensure, liability insurance coverage, liability claims, criminal history, and Drug Enforcement Administration (DEA) status.

35. Critical Incident – An incident that fits within one of the following categories.

a) Abuse – The intentional or negligent infliction of physical pain, injury or mental injury (Idaho Code – 39-5302(1).

b) Exploitation – An action which may include, but is not limited to the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage. Idaho Code 39-5302 (7)

c) Suspicious death of an Enrollee - A death is labeled as suspicious when either a crime is involved, accident has occurred, the death is not from an expected medical prognosis, an Enrollee dies unexpectedly under care, or when an Enrollee's death occurs because of trauma in a medical setting.

d) Hospitalizations – When an Enrollee is hospitalized as a direct result of an incident by a paid provider (medication error, physical injury, quality of care, neglect, treatment omission, or failure to follow established plans of care).

e) Injury Caused by Restraints – An injury to an Enrollee is caused by any of the following restraints:

(1) Physical restraint is any manual method or physical or manual device, material, or equipment attached or adjacent to the Enrollee's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body;

(2) Chemical restraint is any drug that is used for discipline or convenience and not required to treat medical symptoms.

(a) Discipline is defined as any action taken by the provider for the purpose of punishing or penalizing an Enrollee.

(b) Convenience is defined as any action taken by the provider to control an Enrollee's behavior or manage an Enrollee's behavior with a lesser amount of effort by the provider and not in the Enrollee's best interest.

(c) Medical symptom is defined as an indication or characteristic of a physical or psychological condition.

f) Medication error - Any type of medication related mistake that may negatively impact an Enrollee's health or cause him/her serious injury.

g) Neglect– Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain life and health of a vulnerable adult or child, or the failure of a vulnerable adult to provide those services to him/herself. Idaho Code 39-5302 (8)

h) Enrollee is missing – An Enrollee's whereabouts is unknown whatever the circumstances of the disappearance.

i) Enrollee is the victim of a crime – An Enrollee who suffers harm as a direct result of an act committed, or allegedly committed, by another person in the course of a criminal offense.

(1) Harm means the Enrollee suffered actual physical harm, mental injury, or the Enrollee's property was deliberately taken, destroyed, or damaged.

j) Enrollee committed a crime – The Enrollee is charged with a misdemeanor or felony.

k) Safety – The Enrollee is placed in a position of danger and risk either intentionally or unintentionally.

l) Serious injury – An injury that requires professional medical treatment, e.g. hospitalizations, fractures, and wounds requiring stitches.

36. Cultural Competence – Understanding those values, beliefs, and needs that are associated with Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

37. Denied Claim - A claim for which no payment is made to the network agency by the Health Plan for any of several reasons.

38. Developmental Disability (DD) - A chronic disability of a person which appears before the age of twenty-two (22) years of age and:

a) Is attributable to an impairment, such as intellectual disability, cerebral palsy, epilepsy, autism, or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments;

b) Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and

c) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and individually planned and coordinated.

39. DD Plan Developer - A paid or non-paid person identified by the participant who is responsible for developing a DD plan of service and subsequent addenda based on a person-centered planning process. Paid plan developers may not provide direct services to an Enrollee. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in IDAPA 16.03.10.729 through 732.

40. DD Plan Development – Person-centered plan development is a required process in which the Enrollee, and individuals who are significant to the Enrollee, identify services and supports that enable the Enrollee to reside safely and effectively in the setting of their choice. In developing the plan of service, the plan developer and Enrollee must identify any services and supports available outside of Medicaid-funded services that can help the Enrollee meet desired goals. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service.

41. DD Plan Monitor - A person who oversees the provision of services on a DD service plan on a paid or non-paid basis. Plan monitoring is a required activity. Frequency of monitoring must be identified by the Enrollee's planning team, but must occur at least every ninety (90) days consistent with IDAPA 16.03.10.513.05. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor.

42. DD Targeted Service Coordination – An optional Medicaid Enhanced Plan benefit which assists individuals eligible for DD 1915(i) State Plan Amendment Option and 1915(c) DD Waiver services in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. For Enrollees accessing DD Targeted Service Coordination, the DD service plan must specifically address the service coordination needs of the Enrollee as identified by the service coordination assessment. The focus of the service coordination assessment is to identify the Enrollee's need for assistance in gaining and coordinating access to care and services. DD Targeted Service Coordination is a brokerage model of case management and must be provided as described in IDAPA 16.03.10.720-736.

43. DD Targeted Service Coordination Agency – An organization approved by IDHW to provide management, supervision, and quality assurance for paid plan development, plan monitoring, and/or DD Targeted Service Coordination services and includes at least two (2) individuals, one (1) supervisor and one (1) service coordinator. Typically, DD Targeted Service Coordination agencies are privately owned organizations, but they may be community-based providers, non-profit organizations, organizations associated with large health systems, faith-based organizations, etc.

44. DD Targeted Service Coordinator - An individual who provides paid plan development, plan monitoring, and/or DD Targeted Service Coordination services to an eligible Enrollee consistent with requirements identified in IDAPA 16.03.10.513 and IDAPA 16.03.10.720-736, must be an employee or contractor of a Targeted Service Coordination agency that has a valid provider agreement with the Department, and meets training, experience and other

requirements identified in IDAPA 16.03.10.729. DD Targeted Service Coordinators are required to participate in, and provide, DD service plan development, plan monitoring, and/or DD Targeted Service Coordination services to Enrollees accessing 1915(c) Traditional DD Waiver services and/or 1915(i) services.

45. Disaster - An occurrence of any kind that severely inhibits the Health Plan's ability to conduct daily business or severely affects the required performance, functionality, efficiency, accessibility, reliability, or security of the Health Plan's Information System. Disasters may include natural disasters, human error, computer virus, malfunctioning hardware, or electrical supply.

46. Discharge Planning – The evaluation of an Enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.

47. Disenrollment – Elections made after the effective date of enrollment into a Medicare Medicaid Plan.

48. Dual Eligible – Any person, aged twenty-one (21) or older at the time of enrollment, entitled to or enrolled in Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Medicare Part D, and eligible for full Medicaid benefits is considered dually eligible. An individual is considered twenty-one (21) years of age as of the first day of the month after the month of their twenty first (21st) birthday.

49. Dual Eligible Qualified Medicare Beneficiary (QMB) Plus individuals - individuals who are entitled to Medicare Part A, have income of less than seventy five percent (75%) for individuals and eighty-three (83%) for couples of the federal poverty level, resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.

50. Dual Eligible Specified Low-Income Medicare Beneficiary (SLMB) Plus individuals - individuals who are entitled to Medicare Part A, have income of greater than one hundred percent (100%) of the federal poverty level but less than one hundred twenty percent (120%) of the federal poverty level, resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits.

51. Durable Medical Equipment – Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant.

52. Electronic Data Interchange (EDI) Transactions - Electronic data interchange (EDI) is a method for transferring data between different computer systems or computer networks.

53. Electronic Health Record (EHR) - An electronic record of health-related information on an individual that:

a) Includes patient demographic and clinical health information, such as medical history and problem lists; and

b) Has the capacity:

(1) To provide clinical decision support;

(2) To support physician order entry;

(3) To capture and query information relevant to health care quality; and

(4) To exchange electronic health information with, and integrate such information from other sources.

54. Eligibility Redetermination – The process by which Idaho Medicaid Participants must complete certain forms and provide certain verifications in order to establish continued Medicaid eligibility. This process may be required annually, or may be in response to certain changes in the Participant's circumstances.

55. Eligible Individual – With respect to Idaho Home Choice Money Follows the Person (IHCMFP) Rebalancing Demonstration and pursuant to Section 6071(b)(2) of the Deficit Reduction Act of 2005 (DRA), (Pub. L. 109-171(S. 1932)) (Feb. 8, 2006) as amended by Section 2403 of the Patient Protection and Affordable Care Act of 2010 (ACA), (Pub. L. 111-148) (May 1, 2010), the State's approved Money Follows the Person (MFP) Operational Protocol and IHCMFP rules, an eligible individual is a Participant who qualifies for MFP. To be deemed eligible such person, immediately before beginning participation in the IHCMFP demonstration project shall:

a) Reside in a Nursing Facility (NF), an Institution for Mental Diseases, (IMD), or an ICF/ID and have resided for a period of not less than ninety (90) consecutive days in a Qualified Institution.

b) Inpatient days in an IMD which includes Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) may be counted only to the extent that Medicaid reimbursement is available under the State Medicaid plan for services provided by such institution.

c) Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitation services covered by Medicare shall not be counted for purposes of meeting the ninety (90) day minimum in a Qualified Institution established under ACA.

d) Short-term continuous care in a NF, to include Level 2 NF reimbursement, for episodic conditions to stabilize a condition rather than admit to hospital or to facilitate hospital discharge, and inpatient rehabilitation facility services provided in a Qualified Institution shall be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under ACA.

e) Be eligible for and receive Medicaid benefits for inpatient services furnished by the NF or ICF/ID for at least one (1) day. For purposes of this contract, an eligible individual must reside in a NF and be enrolled in the Health Plan for a minimum of one (1) day.

f) Meet NF or ICF/ID level of care, as applicable, and, but for the provision of ongoing HCBS, continue to require such level of care provided in an inpatient facility or meet at-risk level of care such that, in the absence of the provision of a moderate level of home and community based services, the individual's condition and/or ability to live in the community will likely deteriorate and result in the need for institutional placement.

56. Emergency Medical Condition – A medical condition, whether physical or behavioral health related, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of an Enrollee or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

57. Emergency Medical Transportation – The medically necessary transportation of an Enrollee experiencing an emergency medical condition.

58. Emergency Room Care – Outpatient medical services rendered in a hospital setting to treat an Enrollee experiencing an emergency medical condition.

59. Emergency Services – Covered inpatient and outpatient services, including BH services, which are furnished to an Enrollee by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

60. Emergency Service Program (ESP) – Services provided through designated, contracted providers which are available seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health crisis. An ESP encounter includes, at a minimum, crisis assessment, intervention, and stabilization.

61. Enrollee(s) – Any Dual Eligible individual who is enrolled in the Health Plan's Medicare-Medicaid Coordinated Plan under this contract.

62. Enrollee Communications - Materials designed to communicate to Enrollees Plan benefits, policies, processes, and/or Enrollee rights.

63. Enrollment - The processes by which an individual who is eligible is enrolled in a participating Health Plan.

64. Evidence-Based Practice –Strategies supported by scientific research that are identified, assessed, and implemented.

65. Excluded Services – Services that are not included in the MMCP benefit package. These include services that are paid for under Medicaid fee-for-service and services that are not included under the Medicaid Basic and Enhanced Plans.

66. Family Member - A person with any of the following relationships to the Enrollee, whether related by blood, marriage, or adoption, and including such relationships (as applicable) that may have been established through longstanding [one (1) year or more] foster care when the Enrollee was a minor:

a) Spouse, and parents and siblings thereof;

b) Sons and daughters, and spouses thereof;

c) Parents, and spouses and siblings thereof;

d) Brothers and sisters, and spouses thereof;

e) Grandparents and grandchildren, and spouses thereof; and

f) Domestic partner and parents thereof, including domestic partners of any individual in b through e of this definition. A domestic partner means an adult in a

committed relationship with another adult. Committed relationship means one in which the Enrollee, and the domestic partner of the Enrollee, are each other's sole domestic partner (and are not married to or domestic partners with anyone else); and share responsibility for a significant measure of each other's common welfare and financial obligations.

(1) Step and in-law relationships are included in this definition, even if the marriage has been dissolved, or a marriage partner is deceased.

(2) Family member may also include the member's legal guardian or conservator or someone who was the legal guardian or conservator of the member when the member was a minor or required a legal guardian or conservator.

67. Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended to provide primary health care and related diagnostic services to individuals on a sliding fee schedule. The FQHC may also provide dental, optometric, podiatry, chiropractic, and BH services.

68. Fee-For-Service (FFS) – A method of paying an established fee for a unit of health care service.

69. Fiscal Abuse – Actions or inactions by Providers (including the Health Plan) and/or Enrollees that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the IDHW.

70. Fiscal Intermediary (FI) Agency – An entity that provides services that allow the Enrollee receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the Enrollee control over the manner in which services are delivered.

71. Fiscal Year (FY) - The budget year. The federal fiscal year (FFY) is October 1 through September 30. The State fiscal year (SFY) is July 1 through June 30.

72. Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law.

73. Full Benefit Dual Eligible (FBDE) individuals – Dual Eligibles who do not meet the income or resources criteria to qualify as a QMB or SLMB, but are eligible for full Medicaid benefits either categorically or through optional coverage groups, such as medically needy or special income levels for institutionalized individuals or home and community-based waivers.

74. Functional Status – Measurement of the ability of individuals to perform ADLs (e.g., mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and Instrumental Activities of Daily Living (IADLs) (e.g., meal preparation, laundry, and grocery shopping).

75. Grievance - An expression of dissatisfaction about any matter other than an "Action." A grievance is filed and decided at the Health Plan level. Types of Grievances include:

a) Access – Issues involving the availability of services; barriers to obtaining services; or lack of resources/services.

b) Benefit amount – A disagreement by a participant regarding the amount of benefits that they received. Appeal rights must always be discussed with the Enrollee in a benefit amount investigation.

c) Confidentiality & Privacy – 1) Privacy – issues dealing with the rights of Enrollees to access and control their health information and not have it used or disclosed by others against their wishes; 2) Confidentiality – not talking about or disclosing personal information regarding an Enrollee.

d) Contract services – Issues involving an entity providing services under a contract with the Health Plan.

e) Denial of service/eligibility – The denial by the Health Plan to provide or reimburse for a service or program requested by an Enrollee or his/her representative. Appeal rights must always be discussed with the Enrollee in a denial investigation.

f) Discrimination – The prejudicial treatment of individuals protected under federal and/or state law (includes any form of discrimination based on race, color, sex, national origin, age, religion or disability).

g) Fraud – An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. IDAPA 16.03.09.201.05

h) Referrals – Issue or complaint/critical incident dealing with the ability of a Provider or Enrollee to obtain a referral to a Provider.

i) Quality of Care – Issues that involve the meeting or not meeting of rules, policies, or commonly accepted practice standards around care/services provided to Enrollees.

j) Violation of rights – An intentional or unintentional infringement or transgression against an individual's rights.

k) Other – When the grievance does not fit one of the classifications listed, this classification may be used and must describe the nature of the grievance.

76. Grievance Process – The procedure for addressing Enrollees' grievances.

77. Grievance System – The system which includes a grievance process, an appeal process, and access to the IDHW fair hearing system. Any grievance system requirements apply to all three components of the grievance system, not just to the grievance process.

78. Habilitation Services and Devices – Services and devices that support an Enrollee in learning, improving, and retaining skills necessary to reside as independently as possible in the community.

79. Healthcare Services - Services offered or provided by health care facilities and health care providers relating to the prevention, cure or treatment of illness, injury, or disease.

80. Healthcare Professional – A Qualified Intellectual Disabilities Professional (QIDP), physician, physician assistant, podiatrist, optometrist, chiropractor, psychologist, dentist, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

81. Health Insurance – Insurance that pays for medical and surgical expenses incurred by the insured.

82. Health Plan - a participating Health Plan or other qualified entity that has entered into an agreement with IDHW to fulfill the requirements of this Provider Agreement.

83. Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal legislation (Pub. L. 104-191), enacted to improve the continuity of health insurance coverage in group and individual markets; combat waste, fraud, and abuse in health insurance and health-care delivery; simplify the administration of health insurance; and protect the confidentiality and security of individually identifiable health information.

84. Home Health Care – Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in IDAPA 16.03.07, "Rules for Home Health Agencies."

85. Hospice Services – Items and services as described in Title 18, Section 1861 (dd) of the Social Security Act provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan established and periodically reviewed by the individual's attending physician.

86. Hospitalization – An Enrollee is admitted for inpatient hospital services due to an acute level of care need.

87. Hospital Outpatient Care – Services provided in a hospital setting that include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a physician or dentist, unless excluded by other provisions of IDAPA 16.03.09, "Medicaid Basic Plan Benefits."

88. Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID) – A facility designed to meet the needs of four (4) or more individuals with DD or related conditions who require twenty-four (24) hour active treatment services.

89. Idaho Administrative Code (IDAPA) – Idaho's Administrative Code, which has the force and effect of law. IDHW's administrative rules are contained in IDAPA 16, and can be found at: http://adminrules.idaho.gov/rules/current/16/index.html.

90. Idaho Home Choice Money Follows the Person (IHCMFP) Rebalancing Demonstration - A federal grant established under the DRA and extended under the Affordable Care Act that will assist Idaho in transitioning Eligible Individuals from a NF or ICF/ID into a Qualified Residence in the community and in rebalancing long-term care expenditures.

91. ILOC – HCBS – (Institutional Level of Care – Home and Community Based Services) Someone who does not have twenty-one (21) days of institutional based claims within a given month but does have a Home and Community Based provider claim in a month. (Actuarial definition for an Enrollee categorization of all Enrollees based on where claims are paid for the Enrollee in a given month and what type of claims are made.

92. Individualized Care Plan - An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives, to the extent applicable, medical, social, behavioral, and necessary covered services, including LTSS, in a supportive, effective, efficient, timely, and cost-effective manner that emphasizes prevention and continuity of care, and developed by an Enrollee and an Enrollee's Providers. The Individualized Care Plan

must address all of the clinical and non-clinical needs of the Enrollee, including integration of any 1915(c) waiver and/or 1915(i) service plan(s), as appropriate.

93. Information Technology (IT) Systems - The combined application of computers, software, email, network applications, and telecommunications equipment that allows for the storage, retrieval, transmission, and manipulation of data.

94. Institution – A skilled nursing facility, ICF/ID, chronic or rehabilitation hospital, or psychiatric hospital.

95. Institutional Member – Someone with twenty-one (21) days or more of institutional based claims within a given month. (Actuarial definition for an Enrollee categorization of all Enrollees based on where claims are paid for the Enrollee in a given month and what type of claims are made.

96. Institutional Level of Care - The level of care needs required for admission to an institutional setting, such as a NF or an ICF/ID, and the level of care needs required for participation in a 1915(c) home and community-based DD waiver program.

97. Instrumental Activities of Daily Living (IADLs) – Those activities performed in supporting the activities of daily living, including but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community.

98. Licensed, Qualified Professionals – Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho.

99. Long Term Care (LTC) - A variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time.

100. Long Term Care Professional – An employee with a bachelor's degree or a more advanced degree in a relevant field of study, with a minimum of five years of experience in administering long-term care programs.

101. Long-Term Services and Supports (LTSS) – A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives.

102. Marketing – Any communication from the Health Plan to a Medicaid recipient who is not enrolled in the Health Plan, that can reasonably be interpreted as intended to influence the recipient to enroll in the Health Plan, or either to not enroll in, or disenroll from, another Health Plan's Medicaid product.

103. Marketing Materials - Materials that are produced in any medium, by or on behalf of the Health Plan that can reasonably be interpreted as intended to market to potential Enrollees.

104. Material Change to Operations - Any change in overall business operations, such as policy, process, or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Health Plan's membership or Provider network.

105. Medicaid Program Integrity Unit (MPIU) – Division of the IDHW that is dedicated to investigating cases of suspected fraud or abuse.

106. Medicaid Management Information System (MMIS) –Mechanized claims processing and information retrieval system. This system pays claims for Medicaid services and includes information on all Medicaid Providers and participants.

107. Medical Benefits – For the Physical Health, Mental Health, Dental and benefits "Medical" rate cells are defined to differentiate the intensity that the Enrollees use these benefits.

108. Medicaid Waiver – A waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

109. Medically Necessary - A service is medically necessary if:

a) It is reasonably calculated to prevent, diagnose, or treat conditions in the Enrollee that endanger life, cause pain, or cause functionally significant deformity or malfunction; and

b) There is no other equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly.

110. Medicare – Title XVIII of the Social Security Act, the Federal health insurance program for people aged sixty-five (65) or older, people under sixty-five (65) with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

111. Medicare Advantage –The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at Part C, and 42 C.F.R. § 422.

112. Medicare Waiver – A waiver of existing law authorized under Section 1115A of the Social Security Act.

113. National Committee for Quality Assurance (NCQA) - A non-profit organization dedicated to improving health care quality.

114. Network – A group of participating providers linked through contractual arrangements to the Health Plan to supply a range of health and/or support services to Enrollees. These providers have agreed to see Enrollees under certain rules, including billing the Health Plan at contracted rates. The term "provider network" is also used.

115. Network Adequacy – Ability of the Health Plan's provider network, based on the numbers, locations, and types of proficient and appropriate providers, to ensure that all services are accessible to Enrollees without unreasonable delay.

116. Network Provider – An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has a written agreement with the Health Plan, or any subcontractor, for the delivery of services covered under the contract.

117. Network Provider Subcontract - Agreement between the Health Plan and a Provider for the provision of services under the contract.

118. Network Management – The activities, strategies, policies and procedures, and other tools used by the Health Plan in the development, administration, and maintenance of the collective group of health care Providers under contract to deliver Covered Services.

119. Non-participating Provider – A provider that has not enrolled with the Health Plan as a network provider or that has not agreed to accept assignment for all services furnished to Medicare and/or Medicaid participants.

120. Notice/Notice of Action – A written Statement of the Action the Health Plan intends to take, the reasons for the intended Action, the Enrollee's right to file an appeal, and the

procedures for exercising that right. When a decision is appealable, the Health Plan shall advise the Enrollee or provider in writing of the right and method to appeal and the right to be represented.

121. Participating Provider – A provider that has enrolled with the Health Plan as a network provider and has agreed to accept assignment for all services furnished to Medicare and/or Medicaid participants.

122. Performance Measures - Performance measures are specific, operationally defined performance indicators that utilize data to track performance, quality of care, and to identify opportunities for improvement in care and services.

123. Per Member Per Month (PMPM) Rate - The PMPM rate paid to the Health Plan for the provision of services to Enrollees.

124. Per Member Per Month Claim Costs - Equates to all estimated payments for claims expressed in terms of a PMPM distribution.

125. Per Member Per Month Administrative Costs – Equates to administrative costs plus risk/profit margin as expressed in terms of a PMPM distribution.

126. Personal Assistant - A person who meets the standards of Idaho Code § 39-5603, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. A certified nursing assistant (CNA) may be required if the Enrollee's medical condition warrants a CNA.

127. Personal Care Services (PCS) – Personal care to an Enrollee who requires assistance with ADLs and IADLs. This includes physical assistance, cueing, and/or supervision with ADLs and IADLs provided to an Enrollee by a personal care assistant in accordance with the Enrollee's Individualized Care Plan.

128. Pharmacy Benefit Manager (PBM) - A company under contract with the Health Plan that may manage the pharmacy network, drug utilization review, outcomes management, and disease management. The Health Plan may choose to contract with a PBM.

129. Physician Extender – A nurse practitioner or physician assistant functioning as a Primary Care Provider (PCP).

130. Physician Services – Healthcare services furnished or coordinated by a licensed medical physician.

131. Post-stabilization Care Services –Services related to an emergency medical condition, that are provided after an Enrollee is stabilized in order to maintain, improve, or resolve the Enrollee's stabilized condition.

132. Potential Enrollee – A dually eligible person who is not yet enrolled in a Medicare Medicaid Plan.

133. Premium – A regular and periodic charge or payment for health coverage.

134. Prescription Drug Coverage – Health insurance that includes prescription drugs.

135. Prescription Drugs – Pharmaceuticals which are legally obtainable by the order of a licensed prescriber,

136. Prevalent Languages – a language that is the primary language of five percent (5%) or more of the Health Plan's Geographic Service Area population.

137. Primary Care – Health care and laboratory services customarily furnished by, or through, a PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion.

138. Primary Care Provider (PCP) – A practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the Health Plan who is responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. PCPs may be physicians, nurse practitioners, or physician assistants. Physicians must be board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, General Surgery, Obstetrics/Gynecology, Geriatrics, or a physician in any other specialty who chooses to assume the Care Coordination and Care Management functions of the PCP. The nurse practitioners and physician assistants must be licensed as such. Licenses must be held in the state(s) where services are being rendered.

139. Prior Authorization – A written, faxed, or electronic approval that permits payment or coverage of a medical item or service that is covered only by such authorization.

140. Privacy - Requirements established in HIPAA and implementing regulations, as well as relevant Idaho privacy laws.

141. Protected Health Information (PHI) - Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the HIPAA and 45 CFR § 160 and 164.

142. Provider – Any physician, hospital, or other person or entity licensed or otherwise authorized to furnish health care services.

143. Provider Network – The collective group of health care and social support Providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, specialty Providers, mental health/substance use disorder Providers, community and institutional long-term care Providers, pharmacy Providers, and acute hospital and other Providers employed by or under contract with the Health Plan.

144. Provider-Preventable Condition – Includes, consistent with 42 CFR § 447.26, the following:

a) Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients;

b) Wrong surgical or other invasive procedure performed on a patient;

c) Surgical or other invasive procedure performed on the wrong body part;

d) Surgical or other invasive procedure performed on the wrong patient.

145. Prudent Layperson - As defined in the Patient Protections and Affordable Care Act, one who possesses an average knowledge of health and medicine. The standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

146. Prudent Layperson Standard - A standard for determining the need to visit the emergency room, which defines an emergency as a condition that a prudent layperson, 'who possesses an average knowledge of health and medicine.' expects, may result in:

a) Placing the patient in serious jeopardy,

b) Serious impairment of bodily function, or

c) Serious dysfunction of any bodily organs.

147. Qualified Institution – With respect to the IHCMFP Rebalancing Demonstration, and pursuant to Section 6071(b)(3) of the Deficit Reduction Act a hospital, NF, institution for mental diseases (IMD), or ICF/ID.

a) An IMD, which includes Psychiatric Hospitals and PRTF, shall be a Qualified Institution only to the extent that Medicaid reimbursement is available under the State Medicaid Plan for services provided by such institution.

b) Any days that an individual resides in a Medicare certified Skilled Nursing Facility (SNF) on the basis of having been admitted solely for purposes of receiving post-hospital short-term rehabilitative services covered by Medicare shall not be counted for purposes of meeting the ninety (90) day minimum stay in a Qualified Institution established under the Affordable Care Act.

148. Qualified Residence - With respect to the IHCMFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

a) A home owned or leased by an eligible individual or the individual's family member;

b) An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or

c) A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

149. Qualified Intellectual Disabilities Professional – responsible for integrating, coordinating and monitoring services, must have the following qualifications:

a) At least one (1) year of experience working directly with persons with mental retardation or other developmental disabilities; and is one of the following:

(1) A doctor of medicine or osteopathy,

(2) A registered nurse, or

(3) An individual who holds at least a bachelor's degree in a professional category specified in CFR § 483.430.

150. Qualified Residence – With respect to the IHCMFP Rebalancing Demonstration, and pursuant to Section 6071(b)(6) of the DRA, the residence in the community in which an Eligible Individual will reside upon transition to the community which shall be one of the following:

a) A home owned or leased by an Eligible Individual or the individual's family member;

b) An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the Eligible Individual or the individual's family has domain and control; or

c) A residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

d) Additional requirements pertaining to a Qualified Residence set forth in MFP Policy Guidance issued by CMS shall apply for all persons participating in MFP.

151. Quality Management - The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.

152. Readiness Review - Evaluation of the Health Plan's ability to comply with the requirements of this contract including, but not limited to the ability to quickly and accurately process claims and enrollment information, accept and transition new members, and provide adequate access to all Covered Services. At a minimum, readiness review will include a desk review and potentially a site visit to the Health Plan's headquarters.

153. Rehabilitation Services and Devices – Services and devices that support an Enrollee in retaining, improving, or rebuilding skills and functioning for daily living that have been lost or impaired due to illness, injury, or other disabling condition.

154. Reportable Adverse Incident – An occurrence that represents actual or potential serious harm to the well-being of an Enrollee, or to others by the actions of an Enrollee, who is receiving services managed by the Health Plan, or has recently been discharged from services managed by the Health Plan.

155. Retroactive (Late) Enrollment – Occurs when the MMIS receives a Health Plan enrollment after the due date of the monthly enrollment file.

156. Second Opinion - Subsequent to an initial medical opinion, a second opinion is an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

157. Self-direction – A model of service delivery in which the Enrollee receiving personal assistance services, in collaboration with a FI Agency, chooses the level of control he or she will assume in recruiting, selecting, managing, training, and dismissing his personal assistant, regardless of who the employer of record is. Self-direction allows the Enrollee control over the manner in which services are delivered.

158. Service Agreement – A written plan of services developed by the Personal Assistance Agency in conjunction with the Enrollee, or Surrogate, as appropriate, that describes the responsibilities of the Personal Assistant, the Enrollee, the Surrogate, the Personal Assistance Agency, and the Fiscal Intermediary as they relate to the management of the Enrollee's Self-directed PCA Services.

159. Service Area – The specific geographical area of Idaho for which the Health Plan agrees to provide, and is approved to provide Covered Services to all Enrollees who select the Health Plan's Plan.

160. Service Authorization Request – An Enrollee's request for the provision of a service,

161. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI:

a) Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and

b) Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities.

(1) Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.

162. Serious Persistent Mental Illness (SPMI) – An Enrollee must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis.

163. Significant Change - Changes in eligibility standards for benefits, changes in coverage of benefit, reduction in benefit, addition of benefit and/or changes in limitations on services to an Enrollee.

164. Skilled Nursing Care – Skilled care that is within the scope of the Nurse Practice Act, provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, which may include intravenous injections; intravenous feedings; intramuscular or subcutaneous injection; nasopharyngeal feedings; nasopharyngeal and tracheotomy aspiration; insertion and sterile irrigation and replacement of catheters; application of dressings involving prescription medications or aseptic techniques; treatment of extensive decubitus ulcers or other widespread skin disorders; or other direct care activities that require the skills, knowledge, and judgment of a licensed registered nurse.

165. Solvency - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection, and reserves established by IDHW and agreed to by CMS.

166. Special Health Care Needs – Any physical, developmental, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs beyond that typically required by the general population.

167. Specialist – A practitioner with expertise in a specific area of medicine that diagnoses, manages, prevents, or treats certain types of symptoms and conditions.

168. Subcontractor – An individual or entity that enters into an agreement with the Health Plan to fulfill an obligation of the Health Plan.

169. Stakeholder - A person, group, or organization that has a direct or indirect investment, share, or interest in an organization, project, or system because it can affect or be affected by the actions, objectives, and policies of the organization, project, or system. Stakeholders include, but are not limited to rule makers, the State Legislature, professional associations, providers of services, payers of services, funding sources, regulators, Enrollees, and the families of Enrollees.

170. State - The state of Idaho.

171. Supplemental Security Income (SSI) – A United States government program that provides stipends to low-income people who are aged, blind, or disabled.

172. Supplemental Services - Additional benefits not covered in the Medicaid State Plan that enhance the general health and well-being of its Enrollees, including programs that address preventive health, risk factors, or personal responsibility.

173. Telemedicine - The remote diagnosis and treatment of patients by means of telecommunications technology. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology.

174. Third Party Insurance - Casualty insurance, disability insurance, health insurance, life insurance, marine and transportation insurance, motor vehicle insurance, property insurance or any other insurance coverage that may pay for an Enrollee's medical bills.

175. Total PMPM Cost - Equates to PMPM claim costs plus PMPM Administrative costs. This may also be referred to as the base capitation rate for each eligible Enrollee.

176. Transition Manager – An individual that has been certified by IHCMFP to do Transition Management for IHCMFP participants.

177. Transition Management Services – Services that assist individuals in gaining access to needed medical, social, education, and other services for participants moving from a Medicaid-funded institution to a Qualified Residence.

178. Transition Services – Services and items for IHCMFP participants only that are purchased through a Transition Manager, not to exceed two thousand dollars ($2,000), that cannot be obtained by other means, and are essential to the safe and timely transition of a participant into a Qualified Residence.

179. Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Medical Condition.

180. Utilization Management Program – A system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a managed care plan using specified guidelines, as well as providing needed assistance to clinicians or patients in cooperation with other parties, to ensure appropriate use of resources, which can be done on a prospective or retrospective basis, including service authorization and prior authorization.

181. Utilization Review - An element of utilization management, it is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, facilities, and practitioners under the provisions of the applicable health benefits plan. It involves a set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on professional and industry standards. Utilization review is done at the individual Enrollee level as well as a system level.

Attachment 6 - Transition Requirements at Enrollment

Transition Requirements	A&D Waiver Enrollees	NF Enrollees	All Other Enrollees
A&D Waiver Services and Personal Care Services	Maintain service at current level and with current Providers for 90 days or until the Individualized Care Plan is completed, whichever is later. Plan initiated change in service Provider can only occur after an in-home assessment and plan for the transition to a new Provider.	N/A	N/A
Behavioral Health Services	Maintain current Provider and scope of services documented in the Enrollee's treatment plan at the time of enrollment for 90 days or until the Individualized Care Plan is completed, whichever is later.	Maintain current Provider and scope of services documented in the Enrollee's treatment plan at the time of enrollment for 90 days or until the Individualized Care Plan is completed, whichever is later.	Maintain current Provider and scope of services documented in the Enrollee's treatment plan at the time of enrollment for 90 days or until the Individualized Care Plan is completed, whichever is later.
Medicaid Nursing Facility Services	N/A	Maintain current Provider if admission date is prior to enrollment.	N/A
Pharmacy	Requirements for all Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.	Requirements for all Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.	Requirements for all Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.

Attachment 7 - Access Standards

I. Access Standards

A. The Health Plan shall meet access standards, for Provider access as follows for Medicaid Covered services:

B. Travel time is determined based on driving during normal traffic conditions (i.e., not during commuting hours).

C. Distance is measured from the Enrollee's ZIP code of residence.

D. Outpatient Behavioral Health Providers –

1. A minimum of one (1) of each of the following specialists per one thousand (1000) Enrollees:

a) Behavioral Health prescriber,

b) Master's level behavioral health clinician,

c) Case Management provider, and

d) Community-based rehabilitation specialist.

2. Specialists must be located within the following distance and time requirements for all Enrollees using Behavioral Health services:

a) Within thirty (30) miles or within thirty (30) minutes of travel within Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties, and

b) Within forty-five (45) miles or within forty-five (45) minutes in all other counties.

E. Hospital Requirements -

1. Transport time shall not to exceed thirty (30) minutes, except in rural areas where access time may be greater. Any exceptions must be justified, documented, and approved by IDHW.

F. Lab and X-Ray Services -

1. Transport time shall not to exceed thirty (30) minutes, except in rural areas where access time may be greater. Any exceptions must be justified, documented, and approved by IDHW.

G. Institutional Long-Term Care Services –

1. Make every effort to contract with all licensed nursing facilities federally certified to provide care to Medicare and Medicaid participants.

H. Non-Institutional Community LTSS Providers –

1. Each Enrollee shall have a choice of at least two (2) Providers for LTSS services located within:

a) Thirty (30) miles or within thirty (30) minutes of travel within Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties, and

b) Forty-five (45) miles or within forty-five (45) minutes within all other counties.

2. For LTSS provider types that travel to the Enrollee to deliver services, the Health Plan shall ensure that the provider-to-Enrollee ratio is comparable to the provider-to-participant ratio in FFS Medicaid.

I. All other services not specified shall meet the usual and customary standards for the community.

J. Service Delivery Standards - The Health Plan shall facilitate reasonable access to Medicaid Covered Services for Enrollees and shall adhere to the service delivery timeframes below:

ACCESS STANDARD	ACCEPTABLE TIMEFRAME
Non-urgent behavioral care appointments for the treatment of stable conditions.	Within 7 calendar days
24-hour behavioral health crisis coverage, provided by a behavioral health clinician with at least a master's degree. Routine referral to the local emergency room is not acceptable.	24 hours per day/7 days per week

K. The Health Plan may request exceptions to the standards above where this standard is not achievable. IDHW and CMS may grant exceptions to these standards to account for patterns of care for Enrollees, but will not do so in a manner that will dilute access to care for Enrollees.

Attachment 8 - Wellness Assessment

I. Wellness Assessment

A. The Health Plan shall:

1. Complete Wellness Assessments for each new Enrollee on an ongoing basis including:

a) Within ninety (90) calendar days of enrollment. If an Enrollee disenrolls and subsequently re-enrolls in the Health Plan, the Wellness Assessment does not need to be repeated if it was already completed within the previous ninety (90) calendar days,

b) A minimum of once every twelve (12) months (Annual Reassessment) thereafter or as appropriate when there is a change to the Enrollee's health status, needs, or if a significant health care event occurs.

2. Use a standardized, person-centered and IDHW-approved instrument to assess the Enrollee's physical, psychosocial, and functional needs.

a) The instrument must include the following elements:

(1) Current health status and treatment needs;

(2) Social, employment, and transportation needs and preferences;

(3) Personal goals;

(4) Enrollee and caregiver preferences for care;

(5) Back-up plans for situations when caregivers are unavailable;

(6) Informal support networks.

b) Approved instruments must have inter-rater reliability.

3. Use qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Enrollee's needs. Examples of health professionals who may complete portions or all of the Assessment include: Registered Nurses, Licensed Practical Nurses (under supervision of a Registered Nurse), social workers, qualified intellectual disabilities professionals, or mental health counselors. The Health Plan may also utilize individuals with a two-year degree or at minimum two years' experience in healthcare or a healthcare-related industry, preferably as a healthcare paraprofessional, as long as these individuals operate under direct oversight of a qualified health professional.

a) All completed Wellness Assessments shall be made available to the enrollee and/or healthcare professionals when appropriate.

4. For Enrollees receiving LTSS, use the UAI results as part of the Wellness Assessment when appropriate.

a) UAI significant changes must be completed by a registered nurse.

5. Ensure the Enrollee is an active participant in the completion of the Wellness Assessment.

6. Use results of the Wellness Assessment for developing the integrated, individualized Plan of Care.

7. Use relevant and comprehensive data sources, including the Enrollee, Providers, family/caregivers, etc., to complete the Wellness Assessment.

8. Record the Wellness Assessment results in the centralized Enrollee Record.

B. If, as a result of the Wellness Assessment or Annual Reassessment, the Health Plan proposes modifications to the Enrollee's prior Authorized Services, the Health Plan shall provide written notification to the Enrollee, an opportunity to appeal, and the proposed modifications no fewer than ten (10) days prior to implementation of the change to the Enrollee's Individualized Care Plan. The Enrollee is entitled to all appeal rights, including services pending appeal.

C. Share Wellness Assessment or Annual Reassessment data with IDHW upon request.

Attachment 9 - Individualized Care Plan

I. Individualized Care Plan

A. The Health Plan shall:

1. Develop a person-centered, Individualized Care Plan for each Enrollee no later than one hundred twenty (120) calendar days from the time of enrollment or within thirty (30) calendar days of the completion of the Wellness Assessment, whichever occurs first. The Individualized Care Plan must coordinate and integrate all Covered and Supplemental Services, including behavioral health services, for each Enrollee.

2. Develop an Individualized Care Plan template to be approved by IDHW prior to implementation

3. Develop the Individualized Care Plan in conjunction with the Enrollee, their representative, if appropriate, utilizing the Wellness Assessment.

4. Continuously monitor the Individualized Care Plan and ensure any gaps in care are addressed in an integrated manner, including any necessary revisions to the Individualized Care Plan.

5. Ensure that the Individualized Care Plan is updated on an ongoing basis as appointments occur, tests are completed, medications change, transitions made, goals are added or completed, etc.

Attachment 10 - Information Systems

I. General Requirements

A. The Health Plan and IDHW will establish an information technology system work group to coordinate activities and develop cohesive information management processes and Information Technologies Systems (Systems) strategies between the Health Plan and IDHW. The work group will meet on a designated schedule as agreed to by the Health Plan and IDHW.

B. The Health Plan shall:

1. Maintain Systems sufficient to meet IDHW and federal reporting requirements in the formats specified by IDHW.

2. Maintain Systems to perform the data receipt, transmission, integration, management, assessment and analytics tasks for the contracted functions.

3. Ensure Systems are fully compliant with all applicable federal and State laws, rules and regulations including but not limited to HIPAA standards and requirements for privacy, security, and electronic exchange of data and the Health Information Technology for Economic and Clinical Health Act (HITECH).

4. Establish and maintain data exchange trading partner accounts with IDHW's MMIS vendors or other State contractors in the formats and methods defined by the incumbent vendors at no additional cost to IDHW or the incumbent vendors.

5. Make system enhancements necessary to comply with new or updated standards, including all work and testing performed in connection with the enhancements, at no cost to IDHW.

6. Comply with the following:

a) Section 6504(a) of the Affordable Care Act, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Social Security Act

b) Collect data on Enrollee and provider characteristics as specified by the IDHW, and on all services furnished to Enrollees through an encounter data system and process as specified by the IDHW.

c) Ensure that data received from providers is accurate and complete by

(1) Verifying the accuracy and timeliness of reported data, including data from network providers that the Health Plan compensates on the basis of capitation payments,

(2) Screen data for completeness, logic and consistency, and

(3) Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for IDHW quality improvement and care coordination efforts.

d) Make all collected data available to the IDHW and CMS upon request.

B. Electronic Messaging – The Health Plan shall provide a continuously available email system to communicate with IDHW, Providers, and Enrollees capable of attaching and sending documents created using IDHW's currently installed version of Microsoft Office and any subsequent upgrades as adopted and that supports network-to-network encryption of messages containing sensitive data.

II. Systems Refresh Plan

A. The Health Plan shall implement and maintain a Systems Refresh Plan that must be IDHW approved prior to implementation and annually thereafter. The Systems Refresh Plan shall include:

1. How Systems within the Health Plan's control are routinely and systematically assessed to determine the need to modify, upgrade and/or replace the following:

a) Application software,

b) Operating hardware and software,

c) Telecommunications capabilities,

d) Information management policies and procedures, and/or

e) Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, and other relevant factors.

2. How the Health Plan ensures that the version and/or release level of all Systems components are formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

III. Data and Document Management Requirements

A. Data Model and Accessibility - The Health Plan's Systems shall be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant; alternatively, the Health Plan's Systems may employ a relational data model in the architecture of its databases in addition to a relational database management system (RDBMS) to operate and maintain said databases upon approval.

B. Data and Document Relationships - The Health Plan must have an electronic document management solution that includes abilities to scan, index, store, and retrieve documents used to transact business with the IDHW. The Health Plan shall ensure that these documents maintain logical relationships to certain key data such as Enrollee identification and Provider identification number.

1. The Health Plan shall ensure that records associated with a common event, transaction, or customer service issue have a common index that will facilitate search, retrieval, and analysis of related activities, e.g., interactions with a particular Enrollee about a reported problem.

2. The Health Plan shall maintain the capability to generate and provide a listing of all Enrollees and Providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular Enrollees or Providers or groups thereof upon IDHW request.

C. Information Retention - The Health Plan shall, implement and maintain a comprehensive Information Retention Plan that is in compliance with state and federal requirements. The Information Retention Plan shall be provided to IDHW as requested, and shall comply with the applicable requirements of IDAPA 16.03.09 and 16.03.10 and include the following requirements:

1. Maintain information on-line for a minimum of seven (7) years, based on the last date of update activity, and update detailed and summary history data monthly for up to five (5) years to reflect adjustments.
2. Provide forty-eight (48) hour turnaround or better on requests for access to information that is five (5) years old or less and seventy-two (72) hour turnaround or better on requests for access to information six (6) years or older in formats specified by IDHW.
3. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, keep information in electronic form until all tasks or proceedings are completed.

IV. System and Data Integration Requirements

A. IDHW/State Website/Portal Integration - The Health Plan shall conform to the applicable IDHW or State standards for website structure, coding, and presentation if the Health Plan's Web presence is incorporated to any degree to IDHW's or the State's web presence/portal.

B. Compatibility/Interoperability with IDHW Systems and Information System Infrastructure - The Health Plan shall ensure all of the Health Plan's applications, operating software, middleware, and networking hardware and software interoperate as needed with IDHW and/or State systems and shall conform to applicable standards and specifications set by IDHW and/or the State agency that owns the system.

C. Data Exchange in Support of IDHW's Program Integrity and Compliance Functions - The Health Plan's System(s) shall maintain the capability to generate files in IDHW prescribed formats for upload into IDHW Systems used specifically for program integrity and compliance purposes.

D. Address Standardization - The Health Plan shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

V. Encounter Data Provision Requirements (Encounter Submission and Processing)

A. IDHW will:

1. Only use successfully processed medical and pharmacy encounter data to calculate Health Plan capitation rates for future contract amendments.
2. Use encounter data to make programmatic decisions and to monitor Health Plan quality and compliance with federal and State regulatory and contractual requirements.
3. Monitor encounter data for accuracy by reviewing the Health Plan's compliance with internal policies and procedures for accurate encounter data submissions and by random sample audits of claims.

B. The Health Plan shall:

1. Submit an electronic file of all finalized encounter data, including those of its subcontractors to the IDHW and/or its designee on all Medicaid State Plan and Waiver services rendered to an Enrollee.

2. Submit a claims aging report that includes the inventory of claims and the age of the claims in inventory.

3. Submit data certifications for all data utilized for the purposes of rate setting. 42 CFR § 438.604 and § 438.606.

4. Ensure encounter data provides an overall view of an Enrollee's interactions with the Health Plan's Provider network.

5. Comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of claims.

6. Where the Health Plan has entered into capitated reimbursement arrangements with Providers, the Health Plan shall require submission of all utilization or encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

7. Submit all encounter data relevant to the adjudication and payment of claims in sufficient detail, as defined by IDHW, to support comprehensive financial reporting and utilization analysis.

8. Submit encounter data according to standards and formats as defined by IDHW.

9. Research and resolve ninety percent (97%) of individual claims or encounters failing certain edits rejected or reported by IDHW to ensure accurate processing or encounter data quality within five (5) business days or as otherwise agreed by IDHW; including any necessary changes or corrections to any systems, processes, or data transmission formats. The remaining 10% must be researched and resolved within a timeframe agreed upon by IDHW.

   a) Such errors or problems will be considered acceptably addressed when the Health Plan has either confirmed and corrected the reported error or problem or disputed the reported issue with supporting information or documentation that substantiates the dispute.

   b) Failure to research and address reported errors, including submission of and compliance with an acceptable IDHW-approved corrective action plan, if required, may result in damages and sanctions.

10. Immediately notify IDHW when, and correct within two (2) hours unless otherwise agreed upon by IDHW, any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates is rejected and returned to the Health Plan.

11. Ensure the paid amount on encounter data is the amount paid to the provider of service or subcontractor.

   a) The paid amount shall not include related party fees paid such as bonuses, incentives, or advance fee payments.

C. Encounter Data Submission - The Health Plan shall implement and maintain policies and procedures to address its submission of encounter data to the IDHW. The Health Plan shall comply with the following requirements:

1. Before implementation and at least annually, or on a schedule determined by IDHW, the Health Plan shall submit an Encounter Data Work Plan that addresses the Health Plan's strategy for monitoring and improving encounter data submission.
2. Ensure data certification includes certification that data submitted is accurate, complete and truthful, and that all "paid and denied" encounters are for Covered Services provided to or for Enrollees.
3. Screen submitted encounter data for completeness, logic and consistency and ensure all submitted encounter data detail accurately represents the services provided.
4. Ensure the claims are accurately adjudicated according to the Health Plan's internal standards and all federal and State requirements.
5. Fully comply with IDHW monitoring and random sample audits of claims and provide all requested documentation, including, but not limited to applicable medical records and prior authorizations.
6. Have a system in place for verifying and ensuring that Providers are not submitting claims or encounter data for services that were not provided.
7. Contact and offer assistance in reprocessing claims to Providers who bill IDHW for claims that should have been adjudicated when the Health Plan did not correct errors in enrollment or disenrollment transaction requests.
8. Ensure data submission complies with the federal confidentiality requirements of 42 CFR Part 2, and may require the development of Qualified Service Organization Agreements (QSOA).
9. Submit a corrective action plan when required by IDHW and comply with non-compliance remedies for failure to comply with accuracy of these reporting requirements.
10. Collect encounter data in standardized formats to the extent feasible and appropriate.

D. Provision of Encounter Data – The Health Plan shall comply with the following requirements when providing encounter data:

1. Submit all encounter data required to meet Federal and State reporting requirements on a monthly basis to the MMIS in a mutually agreed file format and timeline as defined by State, MMIS vendor and Blue Cross. File must be submitted no later than 30 calendar days from the date of collection.
2. Submit encounter data on a monthly basis in a flat data file format in a mutually agreed upon timeframe.
    a) Failure to comply with the approved format will subject the Health Plan to remedies.
3. Ensure data fields for all encounter data include and are not limited to:
    a) Diagnosis code and DRG, as applicable,
    b) Indication of claim payment status,

c) Identification of claim type (i.e., original or replacement), and

d) Amount of cost-sharing funds required for the claim (i.e. copayment or deductible amounts).

e) Received and paid dates,

f) Provider of service,

g) Enrollee,

h) Procedure codes,

i) Place of service,

j) Billed and payment amounts, and

k) Pay-to Provider.

4. The Health Plan shall submit a minimum of one (1) weekly batch of encounter data, for finalized claims to IDHW's designated agent via Secure File Transfer Protocol (SFTP).

a) Provide IDHW access to the STFP site.

b) IDHW will use a twelve (12) month rolling average of submissions to assess compliance with this encounter data submission requirement.

5. Ensure the electronic data file includes any information related to known TPL for individual Enrollees including, but not limited to:

a) TPL coverage type,

b) TPL eligibility information,

c) TPL recoveries made by the Health Plan, and

d) Any other TPL information requested by IDHW.

6. Include any encounter data from a subcontractor in the encounter data file.

a) The Health Plan shall not submit separate encounter data files from subcontractor(s).

b) Subcontractor encounter data shall be identifiable based on an approved IDHW format.

7. Ensure the encounter data files also contain but not limited to adjustments necessitated by payment errors processed during any payment cycle and encounters processed during any payment cycle from Providers with whom the Health Plan has a capitation arrangement.

8. Ensure the level of detail associated with encounters from Providers with whom the Health Plan has a capitation arrangement is equivalent to the level of detail associated with encounters for which the Health Plan received and settled a fee-for-service claim.

9. Adhere to federal and/or IDHW payment rules in the definition and treatment of certain data elements which are standard fields in the encounter data submissions; e.g., units of service.

10. Institute processes to ensure the validity and completeness of submitted data.

a) Reconcile all encounter data and provide the reconciliation to IDHW and

b) Submit encounter data so payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the Health Plan's applicable reimbursement methodology for that service.

11. The IDHW reserves the right to change format requirements at any time, following consultation with the Health Plan and retains the right to make the final decision regarding format submission requirements.

VI. Eligibility Data Requirements

A. IDHW will provide Enrollee eligibility data each business day via the standard 834 Benefit Enrollment and Maintenance transaction. If the Health Plan needs to verify eligibility on any business day the Health Plan may submit a 270-eligibility request file to IDHW and a 271 eligibility response file will be returned.

B. The Health Plan shall:

1. Establish a secure trading partner account between the Health Plan and IDHW to retrieve Enrollee eligibility and enrollment data.

2. Load daily Enrollee eligibility and enrollment data within two (2) hours of availability for use in eligibility verification, claims processing, and other functions that rely on this Enrollee data.

3. Report their inability to retrieve or load daily eligibility data for any reason to the sending trading partner and the IDHW on the same business day.

4. Not modify Enrollee identifiers, eligibility categories, or other Enrollee data elements without written approval from IDHW.

5. Maintain the capability to uniquely identify each Enrollee across multiple populations and Systems.

6. Ensure the enrollment/Enrollee system includes each of the following data elements:

a) Name,
b) Date of birth,
c) Gender,
d) Telephone number,
e) Permanent residence address,
f) Mailing address,
g) Medicare number,
h) ESRD status,
i) Other insurance Coverage of Benefits (COB) information,
j) Language and Alternative Formats,
k) Enrollee signature and/or authorized representative, as applicable,
l) Date of signature,
m) Authorized representative contact information,
n) Employer or union name and group number,
o) Information provided under "please read and sign below,"
p) Release of information,

q) Option to request materials in a language other than English or in Alternative Formats,

r) Medicaid number, and

s) Data field to identify Enrollees accessing PCS, 1915(c) Traditional DD waiver and/or 1915(i) service plans.

VII. Interface Management and Reconciliation Plan

A. The Health Plan shall implement and maintain an IDHW-approved Interface Management and Reconciliation Plan. After initial IDHW approval, the Health Plan shall update and submit the plan for approval at least annually. The plan shall include, but is not limited to:

1. Identification of all Health Plan, subcontractor, and external data interfaces necessary to support the contract requirements;

2. Processes to identify, manage, and correct discrepancies;

3. Processes to collaborate with IDHW for the reconciliation and correction of errors and records, including timelines; and

4. Detailed documentation of extraction, transformation, and load (ETL) processes used by the Health Plan.

VIII. System and Information Security and Access Management Requirements

A. The Health Plan shall:

1. Ensure all Systems support and maintain compliance with current and future versions of HIPAA Transaction and Code Set requirements, privacy, security, and identifier regulations by their designated compliance dates for electronic health information data exchange and Privacy and Security Rule standards; meeting all required transaction formats and code sets with the specified data sharing agreements required under the regulations.

2. Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security, and all subsequent HIPAA standards, that it will be in breach of the contract and shall take all reasonable steps to cure the breach or end the violation, as applicable.

a) System and operational enhancements necessary to comply with new or updated standards shall be made at no cost to IDHW.

3. Transmit to and receive from its Providers, subcontractors, clearinghouses, and IDHW all transactions and code sets required by the HIPAA regulations in the appropriate standard formats, utilizing appropriate and adequate safeguards, as directed by IDHW to the extent that IDHW direction does not conflict with the law.

4. Adhere to transaction requirements published in Accredited Standards Committee (ASC) X12 Type 3 Technical Reports (TR3).

5. Ensure electronic data exchanges with Idaho's MMIS adhere to both TR3 and MMIS companion guide specifications.

6. Independently obtain and update all reference data needed to meet the requirements above at no cost to IDHW.

7. Make System information available to representatives authorized by IDHW and other federal and State agencies to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed.

8. Ensure all Systems contain controls to maintain information integrity.

   a) These controls shall be in place at all points of processing and tested in periodic and spot audits following a methodology to be developed jointly and mutually agreed upon by the Health Plan and IDHW.

9. Incorporate audit trails into all Systems to trace information on source data files and documents through the processing stages to the point where the information is recorded. The audit trails shall:

   a) Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

   b) Have the date and identification "stamp" displayed on any on-line inquiry;

   c) Have the ability to trace data from the final place of recording back to its source data file and/or document;

   d) Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

   e) Facilitate auditing of individual records as well as batch audits; and

   f) Comply with record retention requirements specified in Idaho Code § 56-209 and § 67-5725.

10. Ensure all Systems have inherent functionality that prevents the alteration of finalized records.

11. Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein.

12. Provide IDHW with access to data facilities upon request and ensure that all collected data is available to IDHW and CMS upon request.

13. Ensure the physical security provisions are in effect for the duration of the contract.

14. Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

15. Include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

16. Put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Health Plan's span of control.

17. Provider and Enrollee service applications shall be accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

a) Ensure that remote access users of Systems can only access them through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by IDHW.

b) Comply with recognized industry standards governing security of federal and State automated data processing systems and information processing. At a minimum, the Health Plan shall conduct a security risk assessment during the readiness review period and annually thereafter, and communicate the results of that assessment in an Information Security Plan provided to IDHW. IDHW shall work with the Health Plan if a corrective action based on the findings is needed. The risk assessment shall also be made available to appropriate federal agencies.

18. Complete Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. An SSAE, SOC 1, Type II audit annually and submit a copy of the audit report to IDHW upon the completion of each audit. The audit must comply with the Centers for Medicare and Medicaid Services (CMS) HIPAA Privacy and Security Rules and the CMS Medicaid Enterprise Certification Toolkit Security and Privacy Checklist an annual SSAE-16 audit.

IX. Systems Performance Standards

A. The Health Plan shall:

1. Ensure all the Systems effectively support automated processes required to perform contract functions.

2. Retain responsibility for the portions of the Systems and communication links for which the Health Plan has responsibility and control. For example, the Health Plan is not responsible for response times while a transmission is traveling over the IDHW's Local-Area-Network.

3. Ensure the System is available to support processing and other contract functions ninety-nine percent (99%) of the time for twenty-four (24) hours, except for scheduled maintenance. The Health Plan shall provide a calendar of scheduled maintenance to IDHW.

4. Ensure cumulative System unavailability caused by factors within the Health Plan's span of control does not exceed one percent (1%) during any continuous twenty (20) calendar day period.

5. Ensure the capability to process EDI and Web Portal transactions (including Prior Authorizations (PAs) ninety nine percent (99%) of the time.

6. Ensure the nightly batch processing activities are completed by 6:00 a.m. Mountain Time the following calendar day.

7. Ensure a maximum of two (2) seconds response time for users of the Health Plan's business applications for editing, print initiation, and navigation between screens ninety five percent (95%) of the time.

8. Ensure a maximum of four (4) seconds response time for users of the Health Plan's business applications, including record searches, retrievals, and web portal functions ninety five percent (95%) of the time.

9. Develop and implement a documented process to monitor all System performance issues and track System downtime and submit the process to IDHW for approval prior to implementation and at least annually.

10. Ensure adequate Health Plan staff is available to address technical system performance issues when identified by Providers, Enrollees, subcontractors, IDHW or other users.

11. Ensure that the systems and processes associated with data exchanges with IDHW are available and operational according to specifications and the mutually agreed upon data exchange schedule.

12. Notify the appropriate IDHW staff via phone, fax, and/or electronic mail within sixty (60) minutes of discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical Systems functions and the availability of critical information; including any problems impacting scheduled exchanges of data between the Health Plan and IDHW. The Health Plan shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes in its notification.

13. Notify the appropriate IDHW staff within fifteen (15) minutes of discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day in order for the applicable work activities to be rescheduled or handled based on System unavailability protocols.

14. Provide information on System unavailability events that impact Enrollee and Provider interaction with the Health Plan, and status updates on problem resolution via electronic mail and/or telephone on at least an hourly basis.

15. Resolve unscheduled System unavailability of high performance environment functions, caused by the failure of Systems within the Health Plan's span of control, and implement the restoration of services as soon as possible. Not be responsible for the availability and performance of Systems and infrastructure technologies outside of the Health Plan's span of control.

16. Ensure for each Enrollee or Potential Enrollee for whom the Health Plan submitted an enrollment or disenrollment record with errors to IDHW, the Health Plan must correct and resubmit the record to IDHW no later than twenty-four (24) hours after IDHW returns the record, provided that IDHW returns the record on Monday, Tuesday, Wednesday, or Thursday. If IDHW returns the record on Friday, Saturday, or Sunday, the Health Plan must correct and resubmit the record to IDHW no later than 11:59 pm on the following Monday.

17. Ensure all other deficiencies are corrected in the timeframes established by IDHW.

X. Business Continuity and Disaster Recovery (BC-DR) Plan

A. The Health Plan shall develop and maintain an IDHW-approved Business Continuity and Disaster Recovery (BC-DR) Plan and submit it to the IDHW for review within thirty (30) days of contract execution. The BC-DR Plan must include:

1. A Systems Contingency Plan developed in accordance with guidelines contained in National Institute of Standards and Technology (NIST) Special Publication 800-34 and 45 CFR 164.308 that includes the following requirements:

a) Data Backup plans,

b) Disaster Recovery plans,

c) Emergency Mode of Operation plans,

d) Application and Data Criticality Analysis and Testing and Revisions procedures,

e) Execute all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within appropriate recovery time objectives (RTOs) for the respective business processes and system components.

f) Data recovery activities must ensure no more than one (1) day of data loss,

g) Protect against hardware, software, and human error,

h) Maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery, and

i) Maintain full and complete back-up copies of data and software on tape or optical disk and store the data in an off-site location approved by IDHW.

2. Continuity planning and execution that encompasses all activities, processes, and resources necessary for the Health Plan to continue to provide mission-critical business functions and processes during a disaster and specifically includes:

a) Coordination with the Systems Contingency Plan to ensure alignment,

b) Processes for restoring critical business functions at an existing or alternate location,

c) Activities to ensure coordination with IDHW and its contractors that ensure continuous eligibility, enrollment, and delivery of services,

d) Notifying IDHW of any disruptions in normal business operations and their plan for resuming normal operations within two (2) hours of identification of the disruption,

e) Ensuring Enrollees continue to receive services with minimal interruption,

f) Ensuring data is safeguarded and accessible,

g) Training Health Plan staff and stakeholders on the requirements of the Systems contingency and continuity plans,

h) Annual exercises to test current versions of Systems contingency and continuity plans, and

(1) The scope of the annual exercises must be approved by the IDHW.

i) Report of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises.

XI. System User and Technical Support Requirements

A. The Health Plan shall provide Systems Help Desk (SHD) services to all IDHW staff and the other approved users with a business purpose and direct access to the Health Plan's Systems. The Health Plan shall:

1. Ensure the SHD is available via local and toll-free telephone service during the period of time between 6:00 a.m. and 6:00 p.m. Mountain Time, Monday through Friday. Availability times are not required for State holidays. Upon IDHW request, the Health Plan shall staff the SHD for extended hours or on a state holiday.

2. Ensure ninety five percent (95%) of calls made between 6:00 a.m. and 6:00 p.m. Mountain Time, Monday through Friday are answered by a SHD staff member.

3. Ensure users who place calls to the SHD can leave a message twenty (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year except for IDHW approved scheduled downtime. The Health Plan's SHD shall respond to messages by noon the following business day.

4. Train staff to answer user questions regarding Systems functions and capabilities; report recurring programmatic and operational problems to the appropriate entity, the Health Plan or IDHW staff for follow-up; redirect problems or queries that are not supported by the SHD via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate IDHW login account administrator.

5. Ensure recurring problems not specific to System unavailability identified by the SHD is documented and reported to Health Plan management within one (1) business day of recognition so that deficiencies are corrected.

6. Maintain a Systems service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. Detail must enable identifying user training needs.

B. The Health Plan shall implement and maintain a formal Change Management process to notify the appropriate IDHW staff of change to the Systems within at least ninety (90) calendar days of the projected date of the change that includes:

C. Notification of major changes, upgrades, modifications, or updates to application or operating software associated with the following core production Systems: (1) claims processing, (2) eligibility and enrollment processing, (3) service authorization management, (4) provider enrollment and data management, (5) (6) encounter data management; and (7) conversions of core transaction management Systems;

D. A system-inherent mechanism for recording any change to a software module or subsystem; and

E. Procedures and measures for safeguarding against unauthorized modifications to Health Plan Systems.

F. Procedures to ensure System unavailability to perform System maintenance, repair, and/or to upgrade activities is not scheduled to take place during hours that may compromise or prevent critical business operations.

XII. System and Operational Readiness Testing

A. Integration and Systems Testing - The Health Plan shall ensure Systems compliance through integrated System testing. The Health Plan shall validate processes with internal testing prior to testing with IDHW. The Health Plan shall:

1. Cooperate with IDHW to develop an Integration and Systems Test Plan and perform Integration and Systems Testing prior to implementation.
2. Provide format and sample contents for Integration and Systems Test Results.
3. Demonstrate to the IDHW that they have successfully met Readiness Review requirements for validating required System functionality. The Health Plan must demonstrate the ability to meet IDHW conditions and testing of their Systems for all categories of the readiness review including:
    a) Data Exchange,
    b) Data Security,
    c) Claims Processing,
    d) Claims Payment,
    e) Provider Systems,
    f) Care Coordination, and
    g) Care Quality Improvement Systems.
4. Demonstrate their System's ability to successfully generate and receive HIPAA compliant EDI transactions necessary to meet contractual requirements including the following:
    a) Standard 835 remittance advice,
    b) Standard 270/271 Eligibility inquiry and response,
    c) Standard 276/277 claim status inquiry and response,
    d) Standard 278 Health Services Review Request and Reply,
    e) Standard 820 premium payment,
    f) Standard 834 enrollment, and
    g) Related functional acknowledgement transactions.
5. Demonstrate their ability to successfully receive, load, transmit, and reconcile data exchanged between the Health Plan and IDHW.
6. Demonstrate their Systems comply with the System and Information Security and Access Management Requirements sections of the contract.
7. Demonstrate their Systems comply with the Systems Performance Standards, Business Continuity and Disaster Recovery (BC-DR) Plan, Systems User and Technical Support Requirements.
8. Demonstrate to IDHW their test results for all required processes in technical reviews and audits.
9. Test additional cases or situations to ensure each functional area is adequately tested, upon IDHW request.
10. Execute and document testing as agreed based on IDHW approved test plans.
11. Cooperate with IDHW for resolution of questions and issues relating to Integration and System Testing of their Systems.

12. Perform any retesting of system functionality as necessary, or as directed by IDHW.

13. Establish a separate test environment for Integration and System Testing that is distinct and separate from all other environments.

14. Provide internal and IDHW staff necessary information to coordinate test activities and assist IDHW in the analysis of test results.

15. Document and correct any incorrect application code, incorrect or inadequate documentation, or any other failure to meet specifications or performance standards, or as directed by IDHW.

16. Conduct technical reviews and audits of integrated, subsystem, and parallel test results to demonstrate to IDHW that all system functions have been completely and accurately tested.

17. Provide a test tracking system which shall record scenarios, indicate status, track test results, and produce reports by subsystem and status for all testing.

18. Provide metrics on the progress of Integration and System Testing.

19. Submit the following Integration and System Testing deliverables:

    a) Integration and System Testing Plan.

    b) Test Data Sets - All transactions must be tested and verified at least thirty (30) days prior to the agreed upon implementation date for initial implementation and subsequent system enhancements during the term of the contract.

    c) IDHW or their vendor validated Base Health Plan system functionality that is in compliance with contract requirements.

    d) Updated Health Plan Systems documentation including job schedules and contact information.

    e) An IDHW-approved data reconciliation plan.

    f) An Integration and System Test Results and Summary Report that includes:

        (1) All test results cross referenced to the expected test results in the Integration and System Test Plan. This includes Integration and System Test results, regression test results, screen prints, test reports, test inputs, and outputs;

        (2) Corrective actions taken and retest documentation for all issues identified in the initial tests and retests;

        (3) Integration and System Test Summary Report that summarizes the work completed and any issues discovered during the Integration and System Testing that includes (1) Summary of the status of testing, including numbers of issues identified by type, number of issues corrected, and any significant outstanding issues, and (2) The effect of any findings on the Systems Implementation Plan.

B. The Health Plan shall ensure all Integration and System Testing milestones are achieved and are accepted by IDHW. IDHW reserves the right to request execution of additional tasks prior to achievement of any milestone. Integration and System Testing milestones include:

1. Acceptance of Test Plan.
2. Acceptance of all Integration and System Test task deliverables.
3. Completion of the Integration and System Test Plan with no unexplained discrepancies, outstanding issues, or errors.
4. Delivery of the Integration and System Test Summary and Integration and System Test Results within the agreed timeline following the completion of final testing.

C. Operational Readiness Testing - The Health Plan shall cooperate with IDHW to develop an Operational Readiness Test Plan and perform an Operational Readiness Test to ensure the Health Plan is ready to perform the basic functions such as processing all inputs and meeting all contract requirements. The Health Plan shall:

1. Perform operational readiness testing that includes a volume test of thirty (30) days of production capacity volumes to demonstrate that the Health Plan and staff are prepared for full production.
2. Provide format and sample contents for the Operational Readiness Report.
3. Demonstrate by testing directly with members of the Provider network prior to implementation of the contract that required system functionality and operational processes are in place for activities conducted between providers and the Health Plan, including:
    a) Provider enrollment,
    b) Maintenance of Provider records,
    c) Claim submission,
    d) Adjudication, and
    e) Payment processes.
4. Work with IDHW to identify the population of Providers who will participate in Operational Readiness Testing ensuring testing of a diverse population that includes different Provider types with high and low transaction volume.
5. Test with all Providers desiring submission of EDI transactions prior to production go-live date.
6. Demonstrate and verify physical security, data security, fire, and disaster prevention and recovery procedures for all Systems.
7. Provide technical staff necessary to coordinate Operational Readiness Test activities and assist IDHW in the analysis of test results.
8. Provide a Systems-tested version of the operational system that is available daily from 6:00 a.m. to 8:00 p.m. Mountain Time, to conduct Operational Readiness Test activities.
9. Prepare an Operational Readiness Report that certifies the Health Plan Systems and all other associated support are in place and ready for implementation.
10. Submit the following finalized deliverables:
    a) Operational Readiness Test Plan.

b) Operational Readiness Report.

c) Systems that are operationally ready and functions in compliance with contractual requirements.

d) An official notification letter indicating the completion of all Operational Readiness Testing activities, and readiness for implementation.

e) Systems Implementation Plan.

D. The Health Plan shall ensure all Operational Readiness milestones are achieved and are accepted by IDHW. IDHW reserves the right to request execution of additional tasks prior to achievement of any milestone. Operational Readiness milestones include:

1. Acceptance of official Health Plan notification letter indicating the completion of all Operational Readiness Testing activities, and readiness for implementation.

XIII. State's Data Warehouse Health Plan Requirements

A. The Health Plan shall participate in a statewide effort to tie all hospitals, physicians, and other providers' information into a data warehouse that shall include, but shall not be limited to claims information, formulary information, medically necessary service information, cost sharing information, and a listing of Providers by specialty.

XIV. Enrollee Website Requirements

A. The Health Plan shall implement and maintain an internet website for Enrollees to access information pertaining to the Health Plan's services. The Health Plan shall:

1. Maintain the website's functionality and ensure its format is readily accessible and that information is placed in a location on the Health Plan's website that is prominent and readily accessible.

2. Ensure the website is operational twenty-four (24) hours a day, seven (7) days a week, with the exception of scheduled maintenance.

3. Schedule maintenance only between the hours of 12:00 a.m. and 6:00 a.m. Mountain Time.

4. Ensure the website is updated with current information on an ongoing basis, and that information is consistent with the content and language requirements of 42 CFR § 438.10.

5. Ensure all new information for the website is submitted to IDHW, prior to posting, for review and acceptance.

6. Ensure the website is updated within ten (10) business days after IDHW reviews and accepts new information.

7. Date each web page, change the date with each revision, and ensure that each page is provided in a format that can be electronically retained and printed.

8. Post the Health Plan's contact information.

9. Post the Enrollment materials for Potential Enrollees.

10. Include an Enrollee portal with access to electronic Explanation of Benefit (EOB) statements.

11. Post Health Plan-distributed literature regarding all health or wellness promotion programs that are offered by the Health Plan.

12. Maintain an up-to-date searchable Provider Directory. The Provider Directory must be made available in a machine-readable file format.

13. Maintain an up-to-date drug formulary. The drug formulary must be made available in a machine-readable file format.

14. Include the HIPAA privacy statement.

15. Include a statement that information is available upon request in alternative formats and how to obtain alternative formats.

16. Include a statement that information is available in paper format without charge within five (5) business days, upon request.

17. Provide links to IDHW's website for general Medicaid and contract information.

XV. Provider Website Requirements

A. The Health Plan shall implement and maintain an internet website for Providers to access information pertaining to the Medicare-Medicaid Coordinated Plan and the Health Plan's Provider policies and procedures. The Health Plan may incorporate the Provider website into the Enrollee website. The Health Plan shall:

1. Include a Provider portal with access to Enrollee information.

2. Maintain the website's functionality.

3. Ensure the website is operational twenty-four (24) hours a day, seven (7) days a week with the exception of scheduled maintenance.

4. Schedule maintenance only between the hours of 12:00 a.m. and 6:00 a.m. Mountain Time.

5. Ensure the website is updated with current information on an ongoing basis.

6. Ensure all new information for the website is submitted to IDHW prior to posting, for review and acceptance.

7. Ensure the website is updated within ten (10) business days after IDHW reviews and accepts new information.

8. Date each web page, change the date with each revision, and allow users the ability to print the information.

9. At minimum, post the following on the website:

a) The Health Plan's contact information;

b) Provider Policies and Procedures Manual and forms;

c) All of Health Plan's Provider education and outreach materials, organized online in a user-friendly, searchable format by type and topic;

d) The HIPAA privacy statement;

e) Links to IDHW's website for general Medicaid and contract information;

f) Claim submission information such as, but not limited to: the Health Plan's submission and processing requirements, paper and electronic submission procedures, and frequently asked questions;

g) Provider claims dispute resolution procedures for in and out-of-network Providers;

h) Prior authorization procedures, including a complete list of Covered Services which require prior authorization;

i) Appeal procedures; and

j) The Health Plan's Provider Directory.

XVI. Secure File Transfer Protocol (SFTP) Requirements

1. The Health Plan shall provide the necessary computer hardware, software, and any other connectivity equipment required to establish and maintain a system with the capability to securely send and receive data necessary to support this contract as follows:

a) The Health Plan shall implement and maintain a server running software capable of SFTP transmissions and interfacing with the IDHW current systems.

b) The Health Plan shall ensure that their systems are functional and accessible to allow the IDHW to retrieve reports from or send reports to the Health Plan via SFTP, when required for this contract.

c) System Requirements - The Health Plan's data system shall meet the following requirements for a SFTP site:

(1) IDHW approved;

(2) Health Plan hosted or by a third party at the Health Plan's expense;

(3) Server with a SFTP;

(4) Secure Socket Layer (SSL) 128-bit encryption or stronger;

(5) Reliable, easy to use, maintain, and troubleshoot;

(6) Health Plan software (i.e., any software that will run at IDHW) shall be compatible with the latest supported versions of Windows;

(7) Ensure qualified Health Plan staffs are trained to use and maintain the data system.

XVII. Auto Assignment

1. IDHW Medicaid Management Information System shall employ an auto-assignment algorithm for the purposes of assigning Full Benefit Medicaid Dual Eligible Beneficiaries in identified Geographical Service Areas (GSA) who do not actively choose a Health Plan.

2. The auto-assignment algorithm will designate equal assignment to health plans based on the unassigned population in each GSA, stratified by participant case mix (Community Well, Home and Community Based Services and Institutional.)

3. Assignment by the algorithm applies to the following members who do not actively choose a Health Plan within the prescribed time limits:

a) New Dually Eligible members.

b) Enrollees enrolled with a Health Plan that is not available after the enrollee moves to a new GSA.

c) Enrollees who disenroll for cause from a Health Plan and do not exercise their right to choose a new Health Plan.

Attachment 11 - Provider Services Helpline, Enrollee Call Center/Helpdesk, and IVR Requirements

I. Provider Services Helpline

A. The Health Plan shall operate a dedicated toll-free Provider Services Helpline staffed with trained representatives knowledgeable about all Provider-related requirements. The Health Plan shall develop Provider Services Helpline policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals from all sources, monitoring of calls via recording or other means, and compliance with standards that include, but are not limited to the following requirements:

1. Ensure the toll-free Provider Services Helpline is staffed a minimum of eight (8) hours per day including during business hours of 8:00 a.m. - 6:00 p.m. MT, Monday through Friday, with the exception of established State holidays described in Idaho State Code 73.1; http://legislature.idaho.gov/idstat/Title73/T73CH1SECT73-108.htm.
2. Provide a voice message system that informs callers of the Health Plan's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within two (2) business days.
3. Ensure all calls are answered by representatives who identify themselves by name to each caller. The Health Plan may utilize an Interactive Voice Response (IVR) system.
4. Have available, at all times, a Telecommunications Device for the Deaf (TDD/TTY) and/or relay systems;
5. Maintain sufficient equipment and staff to ensure the following:
   a) Have at least eighty percent (80%) of calls answered by a trained representative (non-recorded voice), within thirty (30) seconds or less;
   b) Have less than a five percent (5%) abandoned call rate; and
   c) The average wait time for assistance does not exceed one hundred twenty (120) seconds.
6. If an IVR system is used, comply with the requirements in the Interactive Voice Response System section below.
7. Employ representatives who are:
   a) Knowledgeable about Idaho Medicaid, Medicare, and all terms of the contract, including the Covered Services.
   b) Available to Providers to discuss and provide assistance with resolving Provider complaints.
   c) Required to respect the caller's privacy during all communications and calls.
   d) Trained to answer Provider inquiries and concerns from Providers including but not limited to:
      (1) Claims submission and payment questions,
      (2) Claims disputes,
      (3) Appeal process,
      (4) Prior authorization policies and procedures,

(5) Co-pay policies and procedures,

(6) Service referrals,

(7) Training, and

(8) Other relevant inquiries regarding service provision, eligibility, or payment.

e) Trained to interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner.

f) Trained to facilitate access to information on available service requirements and benefits.

8. Provide periodic live monitoring of calls for quality management purposes.

9. Adhere to all regulatory confidentiality requirements.

10. Ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines, including tracing calls when appropriate.

11. Maintain a backup plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning

a) A back-up system capable of operating the telephone system for a minimum of eight (8) hours, at full capacity, with no interruption of data collection;

b) A notification procedure that ensures the IDHW is notified when the Health Plan's phone system is inoperative or a back-up system is being utilized; and

c) Manual back-up procedure to allow requests to be processed if the system is down.

II. Call Center/Help Desk Requirements

A. The Health Plan shall operate a dedicated toll-free Call Center/Help Desk information line staffed with trained representatives knowledgeable about the contracted services. The Health Plan shall develop Call Center/Help Desk information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals from all sources, monitoring of calls via recording or other means, and compliance with standards that include, but are not limited to the following requirements:

1. Establish and publicize the toll-free number throughout Idaho.

2. Provide multiple lines to accommodate Enrollees, Providers, IDHW staff, and any other callers.

3. Ensure that the Call Center/Help Desk information line is staffed a minimum of eight (8) hours per day including during business hours of 8:00 a.m. – 6:00 p.m. Mountain Time, Monday through Friday, with the exception of established State holidays as described in Idaho State Code 73.1; http://legislature.idaho.gov/idstat/Title73/T73CH1SECT73-108.htm.

4. Provide a voice message system that informs callers of the Health Plan's business hours and offers an opportunity to leave a message after business hours. Calls received by the voice message system shall be returned within one (1) business day.

5. Maintain the ability to warm transfer callers to outside entities including, but not limited to Provider offices.

6. Ensure all calls are answered by live operators who identify themselves by name to each caller. The Health Plan may utilize an Interactive Voice Response (IVR) system.

7. Utilize a language line translation system for callers whose primary language is not English.

8. Have available, at all times, a Telecommunications Device for the Deaf (TDD/TTY) and/or relay systems.

9. Maintain sufficient equipment and staff to ensure the following:

   a) At least eighty percent (80%) of calls are answered by a trained representative (non-recorded voice), within thirty (30) seconds or less;

   b) Less than a five percent (5%) abandoned call rate; and

   c) The average wait time for assistance does not exceed one hundred twenty (120) seconds.

10. If an IVR system is used, comply with the requirements in the Interactive Voice Response System section below.

11. Employ representatives who are:

   a) Knowledgeable about Idaho Medicaid, Medicare, and all terms of the contract, including the Covered Services.

   b) Provided access to the Health Plan's Enrollee database and an electronic Provider directory.

   c) Capable of speaking directly with, or arranging for someone else to speak with, Enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service.

   d) Trained in the use of TDD/TTY, Video Relay services, remote interpreting services, and how to provide accessible PDF materials and other Alternative Formats.

   e) Available to Enrollees to discuss and provide assistance with resolving Enrollee complaints.

   f) Required to respect the caller's privacy during all communications and calls.

   g) Trained to interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner.

   h) Trained to answer Enrollee inquiries and concerns from Enrollees and Potential Enrollees, and help Enrollees and Potential Enrollees understand the requirements and benefits of the MMCP, including but not limited to:

      (1) Enrollees' rights and responsibilities,

      (2) How to access oral interpretation services and written materials in prevalent languages and Alternative Formats,

      (3) Eligibility for Plan services,

(4) Procedures for changing plans or opting out of the Demonstration,

(5) Identity, locations, qualifications, and availability of Providers,

(6) Service provision and information on Covered and Supplemental Services,

(7) Appeal process,

(8) Prior authorization policies and procedures,

(9) Service referrals, and

(10) Training.

12. Provide periodic live monitoring of service calls for quality management purposes.

13. Adhere to all regulatory confidentiality requirements.

14. Ensure call tracking and record keeping is established and utilized for tracking and monitoring phone lines, including tracing calls when appropriate, to ensure the safety of the Enrollee or others.

15. Not have a separate number for calls regarding behavioral health and/or long-term care services. The Health Plan may route the call to another entity or conduct a "warm transfer" to another entity, but the Health Plan shall not require an Enrollee to call a separate number regarding behavioral health and/or long-term care services.

16. Report customer service inquiries monthly. All customer service communications, written or verbal, shall be reflected in the Call Center/Help Desk Report.

B. Ensure transfer of ownership of the rights to the toll-free Call Center/Help Desk line number at the conclusion of the contract to IDHW.

1. Maintain a backup plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:

a) A back-up system capable of operating the telephone system for a minimum of eight (8) hours, at full capacity, with no interruption of data collection;

b) A notification procedure that ensures the IDHW is notified on the same business day when the Health Plan's phone system is inoperative or a back-up system is being utilized; and

c) Manual back-up procedure to allow requests to be processed if the system is down.

C. Interactive Voice Response System

1. If the Health Plan chooses to use an Interactive Voice Response System (IVR), the Health Plan shall comply with the following requirements:

2. Provide an up-front message in the phone system to inform users when the IVR is down or experiencing difficulties, including an indication when the IVR is expected to be operational.

3. Roll incoming calls to the Call Center/Help Desk or Provider Helpline staff during instances when the IVR is unavailable during the hours the Call Center/Help Desk is staffed.
4. For IVR users who are seeking data, verify that the person using IVR is an Enrollee or is an individual authorized to access Enrollee data; and allow access to data by Enrollee ID number, social security number, or Enrollee name and date of birth.
5. Assign and provide the IVR user a unique identifier for each inquiry.
6. Provide appropriate safeguards to protect the confidentiality of all information, in compliance with federal, state, and IDHW confidentiality laws, including HIPAA.
7. Provide toll-free telephone number(s).
8. Integrate with the Call Center/Help Desk and Provider Helpline to provide IVR users with an option for staff support when requested during the Call Center/Help Desk and Provider Helpline business hours.
9. Provide sufficient in-bound access lines to meet the requirements of this contract.
10. Ensure the call abandonment rate does not exceed five percent (5%).
11. Ensure that the IVR is available for information and service requests twenty (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year except for IDHW-approved scheduled downtime.
12. Resolve all IVR system downtimes caused by the IVR hardware, software, or other components under the Health Plan's control, within thirty (30) minutes of initial notification of system failure. If the system is not in service within that time frame, the Health Plan shall provide a failover IVR system to ensure that system downtime is limited to a maximum of thirty (30) continuous minutes.
13. Maintain and retain for twenty-four (24) months, electronic records of all IVR inquiries made, information requested, and information conveyed.
14. Make updates to the IVR recorded responses upon request from the IDHW within IDHW-specified timeframes.